

# GASTROENTEROLOGY

New Prescription/Referral  
Prescription Refill

# of Refills:

**Rx:**

Patient Name:

Patient Weight:  
kg

DOB:

**ENTYVIO (vedolizumab):**

300mg IV infusion for 30 mins at week 0, 2, & 6 then Q8weeks thereafter

300mg IV Infusion for 30 mins every 8 weeks

**STELARA (ustekinumab):**

Wt: <56kg: 260mg IV infusion at week 0

Wt: 56 to 85kg: 390mg IV infusion at week 0

Wt: >85kg: 520mg IV infusion at week 0

Inject 90mg SQ every 8 weeks

(\* TB Test Results within 12 months are REQUIRED for:

Entyvio, Stelara, Infliximab, Skyrizi, Omvoh, Tremfya, Tysabri)

**INFLIXIMAB:**

**REMICADE**

**INFLECTRA**

**RENFLEXIS**

**AVSOLA**

3 mg/kg

IV infusion for > 2 hours at week 0, 2, & 6 then Q8weeks thereafter

5 mg/kg

IV Infusion every 8 weeks

10 mg/kg

Others:

**SKYRIZI:**

600 mg OR 1200 mg IV at week 0, 4 and 8 weeks

I 180 mg OR 360 mg SQ at week 12, and every 8 weeks thereafter

**OMVOH:**

300 mg IV infusion at 0, 4, & 8 then 200 mg SQ every 4 weeks

**TREMFYA:**

200 mg IV at 0, 4 & 8 weeks then 200mg SQ every 4 OR 100mg SQ every 8 weeks

**TYSABRI:**

300 mg IV infusion for > 1 hour every 28 days

**Pre-Medication:**

Solumedrol 125mg IVP

Solu-Cortef 100mg IVP

Others:

Tylenol \_\_\_\_\_ mg PO

650mg 975mg

Benadryl \_\_\_\_\_ mg

25mg IV

50mg PO

**ANA Kit Protocol:**

OK to use

**Dx:**

Ulcerative Colitis [K51.90]

Crohn's Disease [K50.90]

OTHERS ( Dx + ICD Code 10 ):

Physician Signature

NPI#:

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

## PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Email:

Fax:

Other:

Office Mailing Address:

Please include  
the following

Patient demographics & Insurance attached

Diagnosis (supporting)

History and Physical

Lab Results

Clinical progress notes

Medication List

TB & Other Test Results

TB Test Results within 12 months (Required for: Entyvio, Stelara, Infliximab, Skyrizi, Omvoh, Tremfya, Tysabri)

Hep B Surface Antigen Results (Required for: Infliximab)

Liver Function Tests & Bilirubin (Required for: Skyrizi, Omvoh)

\*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.