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
☐ 5 mg/kg
☐ 10 mg/kg

☐ IV infusion for > 2 hours at week 0, 2, & 6 then Q8weeks thereafter
☐ IV Infusion every 8 weeks
☐ Others:

SKYRIZI:

☐ 600 mg OR ☐ 1200 mg IV at week 0, 4 and 8 weeks
☐ 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
☐ 900 mg IV infusion at 0, 4, & 8 then 300 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 | **N P I #:** | **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.