GASTROENTEROLOGY

FAX: 725.228.5220

☐ New Prescription/Referral
☐ Prescription Refill

eMediate INFUSION

 # Of Refills:

PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

Name: | DOB: | Weight: kg

PHYSICIAN INFORMATION

Prescriber Name: | Phone: | Fax:

Office Contact: | *Email (for the referral update):

Clinic: | Address:

NPI:

Patient's PCP Name: | Phone: | Fax:

Clinic: | Address:

NPI:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

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
- ☐ 300mg IV at 0 and 2 weeks (IV to subQ dosing)
- ☐ Every _____ 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

Infliximab
- ☐ **Remicade** ☐ **Inflectra** ☐ **Renflexis** ☐ **Avsola**
- ☐ 3mg/kg ☐ IV infusion for > 2 hours at week 0, 2 & 6 then Q8 weeks thereafter
- ☐ 5mg/kg ☐ IV infusion every 8 weeks
- ☐ 10mg/kg ☐ Others: IV infusion every _____weeks

Skyrizi (risankizumab)
- ☐ 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

Tremfya (guselkumab)
- ☐ 200 mg IV at 0, 4 & 8 weeks then ☐ 200mg SQ every 4 OR ☐ 100mg SQ every 8 weeks

Omvoh (mirikizumab)
- ☐ 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

Tysabri (natalizumab)
- ☐ 300 mg IV infusion for > 1 hour every 28 days

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

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

Pre-Medications:

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Other: _____
- ☐ Tylenol _____mg PO ☐ 650 mg ☐ 975 mg
- ☐ Benadryl_____mg PO ☐ 25 mg ☐ 50 mg ☐ IV ☐ PO

ANA Kit Protocol

☐ OK to use

Dx:

- ☐ Ulcerative Colitis [K51.90] ☐ Crohn's Disease [K50.90]
- ☐ Diagnosis _____
- ☐ ICD-10: _____

PRESCRIBER SIGNATURE: x

Date (Valid for 1 year):

I authorize eMediate Infusion Center, PLLC , Assist Point Clinical or its authorized representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to eMediate Infusion Center.

Required Information Please attach

- ☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
- ☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results
- ☐ 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 Hep B results are positive - please provide documentation of treatment or medical clearance & a negative CXR (TB+)**