## **GASTROENTEROLOGY INFUSION** Referral Form

**PHONE** 515.225.2930 | **FAX** 515.559.2495



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above **Patient Information** First Name DOB Gender □M □F Last 4 SSN **Primary Language** Last Name Address City Home Phone Work Phone Cell Phone Email □ Email ☐ DO NOT CONTACT Primary Contact Method (check one) 

Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Primary Caregiver Primary Caregiver/Alt Contact Name (If applicable) Alt Contact Email Alt Contact Phone **Prescriber Information** Name of Contact Sending Referral Title Preferred Contact Method (check one) □ Email ☐ Phone □ Fax Office Phone Office Fax Referral Contact Email Practice/Facility Name Prescriber Name/Specialty Address ZIP \* Please include a copy of the front and back of insurance card. \* Clinical Information - Please include applicable clinical chart notes. Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment **Therapy Start Date** Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: **Date Provided:** Patient Height (cm/in): Weight (kg/lbs): Date Obtained: Therapies Tried and Failed (please list medications) Other/Concomitant Medications (please list) Allergies ☐ NKDA ☐ Drug Allergies (please list) Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list) ICD-10 Code ☐ K50.90 Crohn's disease, unspecified, without complications ☐ Other ☐ K51.90 Ulcerative colitis, unspecified, without complications Prescription Information - Please Escribe if required by state law. In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications ROUTE **DIRECTIONS** REFILLS Starting Dose ☐ Infuse 300 mg IV at weeks 0, 2, 6 and then every ☐ Reconstitute each vial of Entvvio with 4.8 mL of sterile □ 1 month ☐ Entyvio □1 year □IV 8 weeks therafter water and dilute in 250 mL of NS or sterile Lactated 3 months (vedolizumab) Ringers. Infuse over 30 minutes. **Maintenance Dose** ☐ Infuse 300 mg IV every 8 weeks Starting Dose 100 mg vial ☐ Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired does in NS 250 mL to be infused □1 month □ 5 mg/kg Pt weight\_\_\_(kg) =\_\_\_ \_mg IV every 8 weeks ☐ Remicade □1 year □IV over a period NOT less than 2 hours. □ 3 months (infliximab) Maintenance dose 100 mg vial ☐ Additional directions (include daily, weekly, cyclic, one-5 mg/kg Pt weight\_\_(kg) =\_\_ \_mg IV every 8 weeks time, duration of therapy, etc.) Other Loading Dose ☐ Infuse 260 mg IV at week 0 (55kg or less) Loading Dose ☐ Infuse 390 mg IV at week 0 (85kg >55kg) □1 month Dilute the desired dose in 250 mL of NS. Infuse over ☐ Stelara □1 year □IV ☐ Infuse 520 mg IV at wek 0 (>85 kg) 3 months (ustekinumab) a period of at least an hour. Maintenance Dose ☐ Inject 90 mg subcutaneously every 8 weeks (start 8 weeks after infused loading dose) ☐ Vascular Access Method □ Peripheral □ Central □ 3 ml □1 month ☐ Normal Saline □ Before and after infusion □1 year □ 5 mL □ 3 months D5W □ 3 ml □1 month ☐ Heparin 10 units/mL ☐ After infusion □1 year □IV 3 months □ 5 mL ☐ Heparin 100 units/mL ☐ With □ 25 mg □ РО ☐ After infusion □1 year each □ Diphenhydramine □IV □ 50 mg ☐ PRN Allergic Reaction: infusion □ IM ☐ With □ 325 mg □ 500 mg □1 year ☐ Pre-Med: each ☐ 650 mg □ Acetaminophen □РО □1gm infusion Prescriber Signature Date Supervising Physician Signature (where required by state law) NPI# Date DAW (Dispense as Written) Date **Brand Necessary (must handwrite)** 

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific pharmacy and medical board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber. Confidential It may also contain privileged, confidential information which may be proprietary and confidential. It may also contain privileged, confidential information, which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.

## **GASTROENTEROLOGY INFUSION** Referral Form

**PHONE** 515.225.2930 | **FAX** 515.559.2495



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

| Patient Inform   | ation                                       |                  |   |                          |                  |         | ı       |                                   |         |             |            | ,                | I        |                |            |  |
|--|---|------------------|---|--------------------------|------------------|---------|---------|-----------------------------------|---------|-------------|------------|------------------|----------|----------------|------------|--|
| Last Name  |   | First Nam        | ne                                      | DOI                      | 3                |         | Gend    | der 🗆 M                           | □F      | Last 4      | SSN        |                  | Primary  | Language       |            |  |
| Address  |   |                  |   |                          |                  | City    |         |                                   |         |             |            | State            |          | ZIP            |            |  |
| Email  |   |                  | Home Phon                               | ie                       |                  |         |         | Work Ph                           | one     |             |            |                  | Cell Ph  | one            |            |  |
| Primary Contact Me                                     | thod (check one                             | e) 🗆 Cell Ph     | one 🗆 Hom                               | ne Phone                 | □ Work Pho       | ne 🗆    | Text    | ☐ Email                           | □Р      | rimary C    | aregiver   | □ DO NO          | OT CONT  | ACT            |            |  |
| Primary Caregiver/                                     | It Contact Name                             | (If applicable   | e)                                      |                          | Alt Conta        | ct Ema  | ail     |                                   |         |             |            |                  | Alt Con  | tact Phone     |            |  |
| Prescriber Info  | rmation                                     |                  |   |                          |                  |         |         |                                   |         |             |            |                  |          |                |            |  |
| Name of Contact Se                                     |   |                  |   | ті                       | tle              |         |         |                                   | Prefer  | red Cont    | act Meth   | od (check o      | one) 🗆   | Email 🗆 P      | hone 🗆 Fax |  |
| Referral Contact En                                    |   |                  |   |                          |                  |         | Office  | e Phone                           |         |             |            |                  | e Fax    |                |            |  |
| Practice / Facility N                                  | ame   |                  |   |                          |                  |         | Presc   | riber Nar                         | ne / Sr | pecialty    |            |                  |          |                |            |  |
| Address  |   |                  |   |                          |                  | Cit     |         |                                   |         |             |            |                  | State    |                | ZIP        |  |
| Prescriber State Lic                                   | ense #                                      | DEA              | \ #                                     |                          |                  |         | PI #    |                                   |         |             |            | Medica           | aid UPIN | #              |            |  |
|  |   |                  |   |                          |                  |         |         |                                   |         |             |            |                  |          |                |            |  |
|  |   |                  | * Please i                              | include a                | copy of the      | front   | and b   | oack of i                         | nsurc   | ince ca     | rd. *      |                  |          |                |            |  |
| <b>Clinical Inform</b>                                 | <b>ation –</b> Please                       | e include a      | pplicable o                             | clinical c               | hart notes.      |         |         |                                   |         |             |            |                  |          |                |            |  |
| Patient New to The                                     | apy □ Naïve/Nev                             | v Start □ Th     | nerapy Restar                           | rt 🗆 Exist               | ing Treatmen     | t       |         |                                   |         |             | Thera      | py Start Da      | ate      |                |            |  |
| Sample/Starter Prov                                    | rided? □No □Ye                              | es, Provide Qt   | :y: D                                   | ate Provid               | ed:              | Pa      | tient F | Height (cr                        | n/in):  |             | Weight (I  | kg/lbs):         | Da       | Date Obtained: |            |  |
| Therapies Tried and                                    | Failed (please lis                          | t medication     | s)                                      |                          |                  |         |         |                                   |         |             |            |                  |          |                |            |  |
| Other/Concomitant                                      | Medications (ple                            | ase list)        |   |                          |                  |         |         |                                   |         |             |            |                  |          |                |            |  |
| Allergies □ NKDA                                       | ☐ Drug Allergie                             | es (please list) | )                                       |                          |                  |         |         |                                   |         |             |            |                  |          |                |            |  |
| Ship to Address  | Home 🗆 Presc                                | riber's Office   | ☐ Other (p                              | lease list)              |                  |         |         |                                   |         |             |            |                  |          |                |            |  |
|  | (50.90 Crohn's di                           |                  |   |                          |                  |         |         | ☐ Other _                         |         |             |            |                  |          |                |            |  |
|  | (51.90 Ulcerative                           | colitis, unspe   | cified, withou                          | ut complic               | ations           |         |         |                                   |         |             |            |                  |          |                |            |  |
| Prescription In  |   |                  |   |                          |                  |         |         |                                   |         |             |            |                  |          |                |            |  |
| In order for a bran                                    | d name produc                               | ct to be disp    |   |                          |                  |         |         |                                   |         |             |            |                  |          | ions.          |            |  |
| or your state-spec                                     |   | nguage to p      | ronibit subs                            | titutions.               | 11113 101111131  | 101 U V | unu p   |                                   |         |             |            |                  |          |                |            |  |
|  | ific required lar                           | nguage to p      |   | titutions.               | 11113 10111113 1 |         | DIRECT  |                                   |         | ,,,,,,,,,,, |            |                  |          | QTY            | REFILLS    |  |
| or your state-spec                                     | ROUTE                                       | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | стн                                     | kg/>66lbs)               |                  |         | DIRECT  | IONS                              |         |             |            |                  |          | QTY            |            |  |
| or your state-spec                                     | ROUTE                                       | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  | _        | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  | _        | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  | _        | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  | _        | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  | _        | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH<br>D, 0.3 mL (>30                   | kg/>66lbs)               |                  |         | DIRECT  | TIONS<br>Anaphyla                 |         |             |            |                  |          | QTY            | □1 year    |  |
| or your state-spec MEDICATION  □ Epinephrine  □ Other: | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH  2), 0.3 mL (>30  3), 0.3 mL (15-3) | kg/>66lbs)<br>0kg/33-66l | bs)              |         | DIRECT  | Anaphyla<br>Anaphyla<br>ating Dos | se:     |             |            |                  |          | QTY  Once      | □ 1 year   |  |
| or your state-spec  MEDICATION  □ Epinephrine          | ROUTE I I I I I I I I I I I I I I I I I I I | DOSE/STREN       | GTH  2), 0.3 mL (>30  3), 0.3 mL (15-3) | kg/>66lbs)               | bs)              |         | DIRECT  | Anaphyla<br>Anaphyla<br>ating Dos | se:     |             | re require | _<br>ed by state |          | QTY            | □1 year    |  |

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific pharmacy and medical board guidelines such as e-prescribing, state specific prescription form, fox language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber. Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information, which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.

## **Prescriptions**



|   |                      |   |                                       |                     |  | INI                     | USION CARE |
|---|----------------------|---|---------------------------------------|---------------------|--|-------------------------|------------|
| Patient Last Name                                 |                      |   | Pa                                    | DOB                 |  |                         |            |
| Prescription Informa                              | ation                |   |                                       |                     |  |                         |            |
| MEDICATION  | ROUTE                | DOSE/STRENGTH   |                                       |                     | DIRECTIONS   | QTY                     | REFILLS    |
| □ Entyvio<br>(vedolizumab)                        | □IV                  | Starting Dose  Infuse 300 mg IV at weeks 0, 2, 6 and then every 8 weeks therafter  Maintenance Dose  Infuse 300 mg IV every 8 weeks                                   |                                       |                     | ☐ Reconstitute each vial of Entyvio with 4.8 mL of sterile water and dilute in 250 mL of NS or sterile Lactated Ringers. Infuse over 30 minutes.   | □1 month □3 months      | □1 year    |
| □ Remicade<br>(infliximab)                        | □IV                  | Starting Dose 100 mg vial  None 5 mg/kg Pt weight (kg) = Maintenance dose 100 mg via 5 mg/kg Pt weight (kg) = Other   | al<br>=mg I\                          |                     | ☐ Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired does in NS 250 mL to be infused over a period NOT less than 2 hours.  ☐ Additional directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.). |                         | □1 year    |
| □ Stelara<br>(ustekinumab                         | □IV                  | Loading Dose  Infuse 260 mg IV at week 0 Infuse 390 mg IV at week 0 Infuse 520 mg IV at wek 0 Maintenance Dose Inject 90 mg subcutaneous (start 8 weeks after infused | 0 (85kg >5<br>(>85 kg)<br>sly every 8 | 5kg)<br>3 weeks     | Loading Dose Dilute the desired dose in 250 mL of NS. Infuse over a period of at least an hour.  | □1 month □3 months      | □1 year    |
| □ Normal Saline<br>□ D5W                          | □IV                  | □ 3 mL<br>□ 5 mL  |                                       |                     | ☐ Before and after infusion  | ☐ 1 month<br>☐ 3 months | □ 1 year   |
| ☐ Herparin 10 units/mL<br>☐ Herparin 100 units/mL | □IV                  | □3 mL<br>□5 mL  |                                       |                     | ☐ After infusion   | □1 month □3 months      | □1 year    |
| ☐ Diphenhydramine                                 | □ PO<br>□ IV<br>□ IM | □ 25 mg □ 50 mg □   |                                       |                     | ☐ After infusion ☐ PRN Allergic Reaction:  | ☐ With each infusion    | □1 year    |
| ☐ Acetaminophen                                   | □РО                  | □ 325 mg<br>□ 650 mg  | □ 500 mg                              | g                   | □ Pre-Med:   | ☐ With each infusion    | □1 year    |
| ☐ Epinephrine                                     | □ IM<br>□ SQ         | ☐ Adult 1:1000, 0.3 mL (>30kg<br>☐ Peds 1:2000, 0.3 mL (15-30k  |                                       | s)                  | ☐ PRN Anaphylaxis ☐ Repeating Dose:  | □ Once                  | □1 year    |
| □ Other: □ Vascular Access Method                 | □ Periph             | eral □ Central □ Ot   | ther:                                 |                     |  |                         |            |
| Lab Orders  |                      |   |                                       |                     |  | Total F                 | ?Xs        |
| drug, flushes, needles, syring                    | es, ancillary        | supplies and medical equipme  | nt necessa                            | ary to establish ac | al status and response to therapy. Dispense 1 month of cess and administer medication. Prescription to include epts on behalf of patient for administration in office.   |                         |            |
| Patient Support Prog                              | grams: P             | lease have patient sign   | and da                                | ate to enroll       | in pharmaceutical company assisted supp  | ort program.            |            |
| Patient Signature                                 | Da                   | /<br>ate  | _/                                    | _                   |  |                         |            |
| Prescriber Authoriza                              | tion (No             | stamps. Signature and   | l date m                              | nust be comp        | pleted in prescriber's handwriting.)   |                         |            |
| Prescriber Signature                              |                      |   | /<br>ate                              | _/                  |  |                         |            |

\*\*The information contained in this document will become a legal prescription. Follow all state medical board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.

Date

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information, which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.

Supervising Physician Signature (Dispense as Written)