Care Fusion INFUSION CENTERS

Gastroenterology #1

Fax: 855-733-9898
Phone: 877-460-3905

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

1. **Diagnosis:** ☐ K50.90 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other: _____
2. **Drug Allergies:** _____
3. **Failed Medications:** ☐ NSAIDS _____ ☐ MTX _____ ☐ Biologics _____
   (When) ☐ 6-MP _____ ☐ 5-ASA _____ ☐ Corticosteroids _____
   ☐ Sulfasalazine _____ ☐ Azathioprine _____ ☐ Other: _____
4. **Negative TB Skin Test (PPD Test):** ☐ Yes ☐ No When: _____ (Please Attach)

Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis*

Pre-Medication Orders:

- ☐ APAP ☐ 325mg ☐ 500mg ☐ 650mg - PO 30 minutes before infusion.
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg – PO 30 minutes before infusion OR ☐ 25mg IVP ☐ 50mg IVP
- ☐ Alternate Oral Antihistamines: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mg or ☐ 180mg
- ☐ Methylprednisolone ☐ 40mg IVP ☐ 125mg IVP or other _____ mg IVP
- ☐ Famotidine ☐ 20mg PO ☐ 40mg PO ☐ 20mg IVP ☐ 40mg IVP
- ☐ Ondansetron ☐ 4 mg IVP ☐ 4 mg PO

Labwork: _____ To be Drawn by: ☐ Infusion Clinic ☐ Referring Provider

Medication

Infliximab (Remicade & Biosimilars)

- ☐ ***Preferred*** **- Infusion Clinic Preference (Remicade / Avsola / Renflexis) based on payer directives / availability**
- ☐ **Specific Product:** _____

  Dosage (choose one): 5mg /kg OR _____ mg or _____ mg / kg

  Frequency: Dosing at week 0, 2, and 6 then every 8 weeks

  ☐ Other orders: _____ **Maintenance Refills**: _____

Entyvio (vedolizumab)

Dosage:

- ☐ 300mg IV at week 0, 2, and 6 then every 8 weeks
- ☐ Other orders: _____ **Maintenance Refills**: _____

Cimzia (certolizumab pegol) – *In AIC / HCP office administration only*

Dosage:

- ☐ Induction: 400mg SC at weeks 0, 2, and 4
- ☐ Maintenance dose:
  - ☐ 400mg SC every 4 weeks
  - ☐ 200mg SC every 2 weeks

Maintenance Refills: _____

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ ***Physician Signature:*** _____ ***Date:*** _____