RELIANT SPECIALTY INFUSION

Gastroenterology #1 Fax: 833-808-0833

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:*** _____