Gastroenterology Infusion

Call: (877) 883-1392 Fax: (256) 429-2221

Patient Information: Name:_____ DOB:_____ Gender: ○M ○F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ Email: _____ Ht: _____ Wt: _____

Care Giver: _____ Allergies: ○ No Known ○ See Attached Charts Other: _____

Last 4 of SSN: **Please include front and back copies of insurance card**

Prescriber Information

Name: _____ NPI: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State:____ Zip:_____ Office Contact: _____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____

○ Crohn's Disease ○ Ulcerative Colitis ○ Irritable Bowel Syndrome

ICD-10:_____ Other:_____

Serious or active infection present? ○Yes ○No

Hep B ruled out or treatment started? ○Yes ○No

TB Test: ○Positive ○Negative Date: _____

Site of Infusion:

○MD's Office ○Hospital Outpatient Clinic

○Infusion Center ○Patient Home ○Other: _____

Prior Failed Treatments	Drug Name & Length of Treatment
○ 5-ASA	
○ Biologics	
○ Corticosteroids	
○ Immunosuppressants	
○ Methotrexate	
○ Surgery	
○ Other	

Infusion Site Information: (Required if Different from Prescriber)

Name: _____ Address: _____ City: _____

State: _____ Zip:_____ NPI: _____ Phone: _____ Fax: _____

Medication	Dosage & Strength	Directions	Qty	Ref
○ Entyvio	○ 300mg/20ml Vial	**Induction Dose:** ○Week 0: Infusion 300mg IV	1	0
		○Week 2: Infusion 300mg IV	1	0
		○Week 6: Infusion 300mg IV	1	0
		Maintenance Dose: ○300mg IV 8 weeks after the last IV dose, then every 8 weeks thereafter	1	
○Remicade	○100mg/20ml Vial	**Induction Dose:** (adult and pediatric patients) ○Week 0: Infusion 5mg/kg IV ○Week 2: Infusion 5mg/kg IV ○Week 6: Infusion 5mg/kg IV		
		Maintenance Dose: ○5mg/kg IV 8 weeks after the last IV dose, then every 8 weeks thereafter ○_____ (dose can be increased to 10mg/kg if patient loses response to medication later on)		
○Stelara	○ 130mg/26ml Vial ○ 45mg/0.5ml Prefilled Syringe ○ 90mg/ml Prefilled Syringe ○ 45mg/0.5ml Vial	**Induction Dose:** ○Patient Weight <55kg: 260mg IV	2	0
		○Patient Weight >55kg to 85kg: 390mg IV	3	0
		○Patient Weight >85kg: 520mg IV	4	0
		Maintenance Dose: ○Inject 90mg SC 8 weeks after the initial IV dose, then every 8 weeks thereafter		
○	○	○		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature_____ Date: _____

Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

Revised 10/15/2020