Gastroenterology Order Form



Fax completed form to:

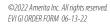
PATIENT INFORMATION						
Patient Name:	3	Date of Birth:		Referral Date:		
Address:				City/State/Zip:		
Home Phone:	(Cell Phone:		Work Phone:		
Secondary Contact:	H	Height:	Weight:	Male Female		
Patient Diagnosis & ICD	Patient Diagnosis & ICD-10:					
Allergies:						
PROVIDER INFORMATION						
Physician Name:	L	Lic.#:		DEA #:		
Practice Name:				NPI#:		
Address:				City/State/Zip:		
Office Contact:		Phone:		Fax:		
Supervisory Physician (if applicable):						
PLEASE ATTACH						
Recent office visit notes, history & physical, lab & pertinent procedure results TB lab results within last 12 months Current medication list & list of prior medications tried and failed (with dates) HBV lab results within last 12 months (Inflized)						
NURSING & LAB ORDERS						
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.						
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mLOR 10units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line						
Lab Orders:						
Lab Date & Frequency:						
PRESCRIPTION ORDERS						
Anaphylaxis Kit:	Epinephrine 0.3mg IM as needed Solu-cortef 250mg-500mg IV as needed Solu-Medrol 60mg - 125mg IV as needed					
(Check all that apply)	Diphenhydramine mg IV as needed NS Hydration 500 ml IV over 30 minutes as needed Other					
Pre-Medications: Acetaminophenmg POminutes prior to infusion Solu-Medrolmg IVminutes prior to infusion (Check all that apply) Diphenhydraminemg POR IVminutes prior to infusion Other						
Check an that apply) Diphennyuramineing POOr IVinitiates prior to initiation Other Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary Other						
PRODUCT	piles for vascular access file care, urug aurifilistia		ON INFORMATIO		REFILLS	
					REFILLS	
Is this a first dose? Yes No If No, when was last dose given? When is patient due for next dose?						
ENTYVIO		, , ,	over 30 minutes at week 0, 2,		NONE	
	Maintenance: 300mg IV infusion via gravity OR pump over 30 minutes every weeks					
INFLIXIMAB	Induction:mg/kg or	mg IV infusion via	gravity OR pump o	over at least 2 hours at weeks 0, 2, and 6	NONE	
Avsola Maintenance: mg/kg mgIV infusion via gravity open provided by the second						
	Inflectra (Note: Round to nearest 100mg for Medicaid patients)					
Remicade Renflexis	If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert.					
	Induction (Adult Dosing -Based on body v	weight of patient at t	time of dosina):			
STELARA	For patients 55kg or less administer 260mg IV infusion via gravity OR pump over at least 1 hour x 1 dose					
	For patients more than 55kg to 85kg administer 390mg IV infusion via gravityOR pump over at least 1 hour x 1 dose					
	For patients more than 85kg administer 520mg IV infusion via gravityOR pump over at least 1 hour x 1 dose NONE					
	Maintenance: 90mg SubQ injection					
		Weeks unter line			NONE	
OTHER	OTHER					
By signing this form and utilizing our services, you are authorizing Eventus to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.						

Prescriber's Signature <u>Dispense as Written</u> Prescril

Date

Prescriber's Signature Substitution Permitted

Date





Print Name

