Gastroenterology Order Form



Fax completed form to:

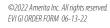
| PATIENT INFORMATION | | | | | | |
|---|---|------------------------|-------------------------------|--|---------|--|
| Patient Name: | 3 | Date of Birth: | | Referral Date: | | |
| Address: | | | | City/State/Zip: | | |
| Home Phone: | (| Cell Phone: | | Work Phone: | | |
| Secondary Contact: | H | 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

