

# Gastroenterology Order Form

Fax completed form to: \_\_\_\_\_



OptionOne  
INFUSION  
An Amerita Company



PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			

PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH	
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Line access documentation/verification if applicable	Vaccine status (any vaccination) and documentation of any recent vaccinations TB lab results within last 12 months HBV lab results within last 12 months (Infliximabs only) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line <b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>

PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b>	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 _____
<b>Pre-Medications:</b>	Acetaminophen _____ mg PO _____ minutes prior to infusion	Solu-Medrol _____ mg IV _____ minutes prior to infusion	
(Check all that apply)	Diphenhydramine _____ mg PO ---OR--- IV _____ minutes prior to infusion	Other _____	
<b>Supply Orders:</b> All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose?	Yes No If No, when was last dose given? _____ When is patient due for next dose? _____	
ENTYVIO	<b>Induction:</b> 300mg IV infusion via gravity ---OR--- pump over 30 minutes at week 0, 2, and 6 <b>Maintenance:</b> 300mg IV infusion via gravity ---OR--- pump over 30 minutes every _____ weeks	NONE
INFLIXIMAB Avsola Inflextra Remicade Renflexis	<b>Induction:</b> _____ mg/kg or _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours at weeks 0, 2, and 6 <b>Maintenance:</b> _____ mg/kg _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours every _____ weeks (Note: Round to nearest 100mg for Medicaid patients) If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert.	NONE
STELARA	<b>Induction (Adult Dosing -Based on body weight of patient at time of dosing):</b> 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 gravity ---OR--- pump over at least 1 hour x 1 dose For patients more than 85kg administer 520mg IV infusion via gravity ---OR--- pump over at least 1 hour x 1 dose <b>Maintenance:</b> 90mg SubQ injection _____ weeks after induction and every _____ weeks thereafter	NONE
OTHER		NONE

By signing this form and utilizing our services, you are authorizing OptionOne to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature \_\_\_\_\_  
 Dispense as Written \_\_\_\_\_  
 Print Name \_\_\_\_\_  
 Date \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_  
 Substitution Permitted \_\_\_\_\_  
 Print Name \_\_\_\_\_  
 Date \_\_\_\_\_



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