

Gastroenterology Order Form

Fax completed form to: _____



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					
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/mL ---OR--- 100units/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	
(Check all that apply)		Diphenhydramine _____ mg IV as needed		NS Hydration 500 ml IV over 30 minutes as needed	
				Solu-Medrol 60mg - 125mg IV as needed	
Pre-Medications:		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	
Supply Orders: 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	Induction: 300mg IV infusion via gravity ---OR--- pump over 30 minutes at week 0, 2, and 6				NONE
	Maintenance: 300mg IV infusion via gravity ---OR--- pump over 30 minutes every _____ weeks				_____
INFLIXIMAB Avsola Inflextra Remicade Renflexis	Induction: _____ mg/kg or _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours at weeks 0, 2, and 6				NONE
	Maintenance: _____ 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.				
STELARA	Induction (Adult Dosing -Based on body weight of patient at time of dosing): 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				NONE
	Maintenance: 90mg SubQ injection _____ weeks after induction and every _____ weeks thereafter				_____
OTHER					NONE

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

Prescriber's Signature Print Name Date
Dispense as Written

Prescriber's Signature Print Name Date
Substitution Permitted

