Gastroenterology Enrollment Form

INFUSE HEALTH

25329 Budde Road, Suite #104
Spring, TX 77380
Phone: 832-713-6119 . Fax: 281-809-6917

PATIENT INFORMATION

Name: _____ DOB: _____ Gender: □ M □ F

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

Phone: _____ Alt. Phone: _____ Email: _____

Language : □ English □ Spanish □ Other: _____ Height: _____ Weight: _____

STATEMENT OF MEDICAL NECESSITY

DIAGNOSIS (ICD-10 CODES): □ **K50.90** Crohn's Disease □ **K51.80** Ulcerative Colitis □ **K58.0** Irritable Bowel Syndrome With Diarrhea (IBS-D) □ **Iron Def. Anema**

Other: _____ Date:_____ Allergies: _____ □ **NKDA**

Prior Failed Treatments:

Biologics: □ Humira □ Entyvio □ Remicade □ Other: _____

□ 5– ASA □ Azathioprine □ Corticosteroids

□ Methotrexate □ 6-MP □ Sulfasalazine □ Other: _____

Patient Evaluation:

□ Crohn's Severity: □ Moderate □ Severe

□ TB Test □ Positive □ Negative

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

PRESCRIPTION INFORMATION

Medication	Dose & Strength	Directions	Qty	Refills
□ **INFLIXIMAB®** **OR** **INFLIXIMAB® BIOSIMILAR** (as Required by Patient's insurance)	□ 100mg IV	□ **DO NOT SUBSTITUTE**, Infuse the following Infliximab product_____ □ **Induction:** IV at 5mg/kg at week 0, week 2, week 6 and every 8 weeks thereafter. □ **Maintenance:** IV at 5mg/kg every 8 weeks □ Other: Dose_____mg/kg Frequency_____: Every _____weeks		
□ **ENTYVIO®**	□ 300mg Vial	□ Infuse 300mg IV over 30min at week 0, week 2, week 6 then every 8 weeks. □ **Maintenance Dose:** 300mg IV over 30 mins Q 8 weeks.	.....	.....
□ **SKYRIZI®**	□ 600mg IV □ 360mg SQ	□ **Induction Dose:** 600mg IV at week 0, 4 and 8. □ **Maintenance Dose:** 360mg sq at week 12, then every 8 weeks thereafter x 1 year. □ **Lab Order:** LFTS to be monitored at baseline Billirubin/during induction + periodically.	.....	.....
□ **STELARA®**	□ 130mg/26ml Vial □ 90mg/ml Syringe	□ **Induction Dose:** Infuse _____ mg x dose. (□ 55kg or less—260mg; □ 55-85kg—390mg; □ 85kg or more—520mg) □ **Maintenance Dose:** 90mg Subq 8 weeks after initial and then every 8 weeks. □ Other:	.....	.....
□ **INJECTAFER®**	□ 15mg/kg □ 750mg	□ **15mg/kg IV** - Give 2 doses at least 7 days apart not to exceed 1500mg. if patient weighing less than 50kg (110lbs) □ **750mg IV** - Give 2 doses at least 7 days apart not to exceed 1500mg. if patient weighing 50kg (110lbs) or greater □ Other:	.....	.....
□ **VENOFER®**	□ 200mg IV □ 200mg IV	□ Administer 5 doses over 14 days. □ Administer weekly x 5 weeks.	.....	.....
□ **ZINPLAVA®**	□ 25mg/ml	□ The recommended dose is a single dose of 10 mg/kg administered as an intravenous infusion over 60 minutes. □ Other:	.....	.....
□ **PREMEDICATION ORDERS**	□ Please select	□ Tylenol; □ 100mg □ 500 mg, PO □ Diphenhydramine 25mg PO/IV □ Cetirizine 10mg PO □ Loratidine 10mg PO □ Solumedrol 125mg IVP □ Solu-Cortef 125mg IVP □ Diphenhydramine 50mg PO/IV		

Prescriber's Signature: _____ □ **DAW (Dispense As Written) Date:** _____

Prescriber's Name: _____ **Phone:** _____ **Fax:** _____

Prescriber's Address: _____ **City:** _____ **State:** _____ **Zip:** _____

NPI: _____ **DEA:** _____ **Tax I.D:** _____ **Office Contact:** _____