Gastroenterology Infusion Order Form

ARISTACARE

Phone: 800.280.3338
Fax: 903.295.0004

Patient Information

Patient Name:__________________________ DOB:_____________

Sex: O Female O Male SSN:______________________________

Language:______________ Wt:____ O kg O lbs Ht:____ O cm O in

Address:____

Apt/Suite:_____ City:________________State:____ Zip:_________

Phone:________________ Alternate Phone:___________________

Caregiver Name:____________________ Relation:_____________

Local Pharmacy:____________________ Phone:_____________

Prescriber & Shipping Information

Prescriber Name:____

NPI:____

Address:____

Apt/Suite:_____ City:________________State:____ Zip:_________

Contact:____

Phone:________________ Alternate Phone:___________________

Fax:____

Email:____

O Ship to Physician's Office O Ship to Patient's Home

Please fax a front and back copy of the Patient's Insurance Card(s)

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: O K50.90 Crohn's Disease O K51.90 Ulcerative Colitis O Other:_______________________________

Has patient received PPD (skin test)? O Yes O No Results:____

Prior Therapy O No O Yes List:__________________________ Reason for Discontinuation:_______________________

Approximate Start Date:______________________________ Approximate Stop Date:_____________________________

Comorbidities:____

Concomitant Medications:____

Allergies O NKDA O Other :______________________________ Is this a first dose? Y N If not, date of last infusion: ______________

Drug	How Supplied	Directions	Quantity	Refill
Entyvio®	O 300mg vial	O Loading dose: Infuse 300mg IV over 30 minutes at week 0, week 2, and week 6	O 3 doses	_________
		O Maintenance dose: Infuse 300mg IV over 30 minutes every 8 weeks	O ________ doses	
		O Other: Infuse 300mg IV over 30 minutes every ______ weeks		
Infliximab	O 100mg vial	O Loading dose: Infuse ____mg/kg IV over 2 hours at week 0, week 2, and week 6	O 3 doses	_________
	O Dispense vials necessary to achieve dose	O Maintenance dose: Infuse ________mg/kg IV over 2 hours every ________ weeks	O ______doses	
		Patient Weight:__________kg		
Skyrizi® (Induction dose)	O 600mg/10ml vial	O Crohn's Loading Dose: Infuse 600mg IV over 1 hour at week 0, week 4, and week 8	O 3 vials	
		O Ulcerative Colitis Loading Dose: Infuse 1200mg IV over 2 hours at week 0, week 4, and week 8	O 6 vials	
Skyrizi® SubQ	O 180mg/1.2ml	O Maintenance dose: 180mg SubQ every 8 weeks starting at week 12 after the initial IV induction dose	O 1 dose	_________
	O 360mg/2.4ml	O Maintenance dose: 360mg SubQ every 8 weeks starting at week 12 after the initial IV induction dose		
Stelara® (Induction dose)	O 130mg/26ml vial	O Low-Dose induction: Infuse 130mg IV over at least 1 hour	O 1 vial	
		O ≤ 55kg: Infuse 260mg IV over at least 1 hour	O 2 vials	
		O > 55kg to 85kg: Infuse 390 mg IV over at least 1 hour	O 3 vials	
		O >85kg: Infuse 520mg IV over at least 1 hour	O 4 vials	
Stelara® SubQ	O 1 x 90mg/ml PFS	O Inject 90mg SubQ 8 weeks after initial IV dose and then every 8 weeks thereafter	O 1 syringe	_________
Tysabri®	O 300mg/15ml vial	O Infuse 300mg IV over 1 hour every 4 weeks	O 1 vial	_________
TPN (Total Parenteral Nutrition) in the home setting: Please send orders separately.				
Other Miscellaneous Orders:_______________________________			O ____________	_________
Other Miscellaneous Orders:_______________________________			O ____________	_________

Injection Training Provided by: O Physician's Office O Pharmacy O Other:

Per state-specific law, prescriptions may be dispensed as generic, if applicable, unless marked "dispense as written"

Prescriber's Signature____ Date:___________________

I authorize the Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at anytime by providing written notice to the pharmacy. Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from dissemination or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling (800) 280-3338 to obtain instructions as to proper destruction of the transmitted material. Thank you.