Gastroenterology Infusion Order Form

AristaCare

Phone: 888.404.6026
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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 (888) 404-6026 to obtain instructions as to proper destruction of the transmitted material. Thank you.