

GASTROENTEROLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD-10 Code plus Description: _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

1) TB test performed? Yes No Date: _____ Results: _____

2) Patient diagnosed with Congestive Heart Failure? Yes No 3) Liver function test normal? Yes No

4) Patient previously treated with Entyvio OR Remicade OR Simponi Aria? Yes No Please select: Entyvio Remicade Simponi Aria Date: _____

5) Hep-B antigen surface antibody test? Yes No Date: _____

PRESCRIPTION ORDERS:

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
- b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE
- c) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

SELECT	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
<input type="checkbox"/>	ENTYVIO (LOADING DOSES)	300 mg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS	
<input type="checkbox"/>	ENTYVIO (MAINTENANCE DOSE)	300 mg	IV	ONCE EVERY 8 WEEKS	
<input type="checkbox"/>	RENFLXIS (LOADING DOSES)	_____ mg / kg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY _____ WEEKS	
<input type="checkbox"/>	RENFLXIS (MAINTENANCE DOSES)	_____ mg / kg	IV	ONCE EVERY _____ WEEKS	
<input type="checkbox"/>	OTHER:	_____ mg / kg	IV	ONCE EVERY _____ WEEKS	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BENADRYL		
<input type="checkbox"/>	ACETAMINOPHEN		
<input type="checkbox"/>	OXYGEN		
<input type="checkbox"/>	SOLU-MEDROL		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	BUN/CREATININE	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CRP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	ESR	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	ALT	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	AST	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	LIVER PANEL	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	VECTRA	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	OTHER:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	

NOTES/INSTRUCTIONS/COMMENTS

Physician's Signature _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.