GASTROENTEROLOGY

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

Rx:

Patient Name:

DOB:

ENTYVIO (vedolizumab):

☐ 300mg IV infusion for 30 mins at
week 0 [**DATE**: _____], week 2 [**DATE**: _____], week 6 [**DATE**: _____]

☐ 300mg IV Infusion for 30 mins every 8 weeks [**START**: _____]

STELARA (ustekinumab):

☐ **Weight < 56 kg**: 260mg IV infusion at week 0 [**DATE**: _____]

☐ **Weight: 56 to 85 kg:** 390mg IV infusion at week 0 [**DATE**: _____]

☐ **Weight: > 85 kg:** 520mg IV infusion at week 0 [**DATE**: _____]

☐ Inject 90mg SC every 8 weeks [**START**: _____]

INFLIXIMAB: ☐ ***REMICADE*** ☐ ***INFLECTRA*** ☐ ***RENFLEXIS***

☐ 5 mg/kg IV infusion for > 2 hours at
week 0 [**DATE**: _____], week 2 [**DATE**: _____], week 6 [**DATE**: _____]

☐ 5 mg/kg IV Infusion for 30 mins every 8 weeks [**START**: _____]

☐ IV Infusion for 30 mins every 8 weeks [**START**: _____] 10 mg/kg 3 mg/kg

OTHERS:

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP

☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Others:

Dx:

☐ **Ulcerative Colitis [K51.90]** ☐ **Crohn's Disease [K50.90]**

OTHERS (Dx + ICD Code 10):

N P I #:

Physician Signature

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Email:

Fax:

Other:

Office Mailing Address:

Please include the following

☐ **Patient demographics & Insurance attached**
☐ **Diagnosis (supporting)**
☐ **History and Physical**
☐ **Lab Results**
☐ **Clinical progress notes**
☐ **Medication List**
☐ **Other Test Results**