

GASTROENTEROLOGY ENROLLMENT FORM

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Patient Name: _____ DOB: / / Height: _____ Weight: _____ kg Date: / /
 Allergies: _____ Email: _____ Ship to: _____ Patient
 Address: _____ Ph: _____ Prescriber Signature _____
 Prescriber: _____ Ph: _____ Fax: _____ MD Office
 _____ Althea Location: _____

DOCUMENTS TO INCLUDE WITH REFERRAL

- Patient demographics
- Face sheet
- Insurance information
- **Labs:** CBC with differential, CMP, Hepatitis B and C), TB Screening, CRP and/or ESR
- Endoscopy or colonoscopy, if applicable
- H&P
- Medications and therapies tried and failed
- Baseline assessment, including detailed patient symptoms
- Attach original prescription orders

DIAGNOSIS

K50.00 Adult Crohn's Disease
 K51.90 Adult Ulcerative Colitis
 K50.00 Pediatric Crohn's Disease
 K76.82 Hepatic Encephalopathy
 Other _____

Hep B/Hep C Test: Positive Negative TTB/PPD: Positive Negative
 Injection Training or Home Health RN visit is necessary: Yes No
 Prior Medication Failed: _____
 Length of Treatment: _____
 Reason for Discontinuation: _____

GASTROENTEROLOGY PRESCRIPTION

DOSAGE AND ADMINISTRATION

Entyvio® (vedolizumab)	Initial: Infuse 300mg IV over 30 minutes at day 0, 14, and 42 Maintenance: Infuse 300mg IV over 30 minutes every _____ weeks. Refills x 1 year.
Inflectra® (infliximab-dyyb) Infliximab (infliximab) Remicade® (infliximab) Renflexis® (infliximab-abda)	Initial: Infuse IV _____ mg per kg (Dose _____ mg) at 0, 2, and 6 weeks. Maintenance: Infuse IV _____ mg per kg (Dose _____ mg) every _____ weeks. Refills x 1 year. Other: Pharmacy to dispense to nearest 100mg vial. Patient to infuse exact dose (do NOT round).
Simponi® (golimumab)	Initial: Inject 200mg SUBQ on day 0, then 100 mg on day 14. Maintenance: Inject 100mg SUBQ every 4 weeks. Refills x 1 year.
Skyrizi® (risankizumab-rzaa)	Crohn's Initial: 600mg administered by IV over at least one hour at week 0, week 4, and week 8. **Induction Dosing Only Ulcerative Colitis Initial: 1200mg administered by IV over at least two hours at week 0, week 4, and week 8. **Induction Dosing Only
Skyrizi® SUBQ	Prefilled cartridge: 180mg 360mg at week 12 and every 8 weeks thereafter 1Ls x 1 year.
Stelara® (ustekinumab)	Initial: Weight based dosing, infuse IV up to 55kg = 260mg (2 vials), > 55kg to 85kg = 390mg (3 vials), > 85kg = 520mg (4 vials) Maintenance: Inject 90mg SUBQ 8 weeks after initial dose, then every 8 weeks thereafter. Refills x 1 year.
Tremfya® (guselkumab)	Crohn's Disease or Ulcerative Colitis (Initial): 200mg IV on weeks 0, 4, and 8. Crohn's Disease (Initial SUBQ Option): 400mg SUBQ (as 2 consecutive 200mg injections) on weeks 0, 4, and 8. Crohn's Disease or Ulcerative Colitis (Maintenance): 100mg SUBQ at week 16, then every 8 weeks thereafter. Refills x 1 year. Crohn's Disease or Ulcerative Colitis (Maintenance): 200mg SUBQ at week 12, then every 4 weeks thereafter. Refills x 1 year. Plaque Psoriasis or Psoriatic Arthritis (Initial + Maintenance): 100mg SUBQ at weeks 0 and 4, then every 8 weeks thereafter.
Other:	

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.

Premedications & Other Medications - Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

Acetaminophen _____ mg PO prior to infusion Diphenhydramine _____ mg PO Other: _____