GASTROENTEROLOGY ENROLLMENT FORM

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ALTHEA
INFUSION & SPECIALTY PHARMACY™

★ Patient Name: _____ DOB: / / Height: _____ Weight: _____kg Date: / /

Allergies: _____ Email: _____

Address: _____ Ph: _____

★ Prescriber: _____ Ph: _____ Fax: _____

★ Prescriber Signature

_____

Sip to:A
- ☐ Patient
- ☐ MD Office
- ☐ Altea Location:A

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DOCUMENTS TO INCLUDE WITH REFERRAL

- ★ • Patient demographics
- ★ • Copies of insurance card (front and back)
- ★ • Pharmacy Card
- ★ • **Recent Lab Results**: Antibody panel, BUN/SCr, IgA level, and EMG/NCV studies
- ★ • Specialist consults and recent progress notes
- • Prior medications and therapies (failed or inadequate response)
- • Relevant imaging studies (MRI, CT, X-ray, etc.)
- • Baseline functional assessment with detailed symptom history

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)	☐ **Intial:** 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 lls 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: _____