DeliverIt Pharmacy
Infusion & Specialty

Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478

GASTROENTEROLOGY Infusion Orders

F: 832.939.8128 T: 832.939.8137

PATIENT INFORMATION

Patient Name: ______________________________ Social Sec #: ____________ Weight: _____ lbs
D.O.B: ____________ Sex: Male ____ Female _____ Height: _____ lbs
Phone: __________________
Address: ____ City: __________ State: ____ Zip Code: __________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis Date: _______ **ICD-10:** _______ **Allergies**: ____

****Date of last ☐ Orencia ☐ Remicade ☐ Humira ☐ Enbrel dose:** _______

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ____

Hepatits B Protocol: Hep B surface antigen and Hep B Core AB total required. (Cimzia, Infliximab)

Hepatits B Labs: ☐ Hep B antigen attached ☐ Hep B Core antibody total attaced ☐ Draw Hep B Labs (Cimzia

TB Protocol: Baseline Testing: Quantiferon Gold (QFT Gold) or PPD (Cimzia, Infliximab, Stelara and Entyvio)

TB Test: ☐ Hep B antigen attached ☐ Hep B Core antibody total attaced

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Iron Deficiency Anemia ☐ Iron Deficiency Anemia with CKD not on dialysis **Required Recent Labs: CBC, Ferritin, Iron Studies**	☐ **Venofer** 200mg IV q 3 weeks x 5 doses ☐ **Venofer** 100mg IV q week x 7 weeks then every other week x x7 weeks ☐ **Venofer** 200mg IV - Administer 5 doses over a 14 day period ☐ **Venofer** 200mg IV weekly x 5 weeks ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg if patient weighing less than 50kg (110lbs) ☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500 mg if patient weighing 50kg (110lbs) or greater	☐ ________ ☐ x 1 year
☐ Crohn's Disease ☐ Ulcerative Colitis	☐ **Cimzia** 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks ☐ **Cimzia** _______mg Sub-Q every _________ weeks ☐ **Infliximab** Brand's available : ☐ Inflectra ☐ Remicade ☐ Renflexis **Dose:** ___________mg/kg **Frequency** ☐ Every __ weeks OR ☐ 0, 2, 6 then every 8 weeks Pre-medication Orders ☐ Tylenol 1000mg Antihistamine: ☐ Cetrizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO Additional Pre-Medication Orders ☐ Solu-Medrol 62.5mg IVP ☐ Solu-Medrol 125mg IVP ☐ Solu-Cortef _______mg IVP ☐ **Stelara** initial infusion: ☐ <55kg 260mg IV over 1 hour x 1 dose ☐ 55kg to 85kg 390mg IV over 1 hour x 1 dose ☐ >85kg 520mg IV over 1 hour x 1 dose ☐ **Stelara** maintainance: ☐ 90mg SQ 8 weeks after initial and then every 8 weeks ☐ **Tysabri** 300mg every 4 weeks ☐ JCV antibody ☐ Patient TOUCH authorization ☐ **Entyvio** 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8weeks (baseline LFTs) ☐ **Entyvio** 300mg IV every 8 weeks	☐ ________ ☐ x 1 year
	Hypersensitivity/Anaphylaxis Response Protocol PRN	

PHYSICIAN INFORMATION

By signing this form and utilizing your services, you are authorizing DeliverIt Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ______________________________ Date: __________________

Physician Name: ________________________________

Phone: _____________ Fax: ______________ Contact Person: __________________