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 **Hypersensitivity/Anaphylaxis Response Protocol PRN**	☐ **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 Pre-medication Orders ☐ Tylenol 1000mg ☐ Diphenhydramine 25mg ☐ Ondacetron 4mg IV PRN for nasuea ☐ Solu-Medrol 125mg + Cetirizine ☐ **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 Pre-medication Orders ☐ Diphenhydramine 25mg ☐ Acetaminophen 650mg PO ☐ Solu-Medrol _____mg IVP ☐ Solu-Cortef_____mg IVP	☐ _____ ☐ x 1 year

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: _____