US infusions
11500 State Hwy 121 Ste 910, Frisco, TX 75035
4708 Dexter Dr., Ste 350, Plano, TX 75093
P: 469-200-2605 F: 469-200-2606 usinfusions.org

GASTROENTEROLOGY ORDER SET

PATIENT INFORMATION:

Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ Height: _____ ☐ inches ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

Diagnosis Code ICD-10 (required): _____ **Diagnosis Description:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Treatment Date: _____

PHYSICIAN INFORMATION:

Prescriber Name: _____ Phone: _____ Fax: _____

Office Contact: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

NPI #: _____ DEA #: _____ Tax ID: _____

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

PRESCRIPTION INFORMATION (or attach copy of the prescription)

Drug	Dosing	Refills
Cimzia (certolizumab pegol)	☐ 400mg subQ at weeks 0, 2, 4 and then every 4 weeks ☐ _____ mg subQ every _____ weeks	☐ x1 year ☐ _____
Entyvio (vedolizumab)	☐ 300mg IV at 0, 2, 6 weeks and then Q8 weeks ☐ 300mg IV every 8 weeks ☐ 300mg IV at 0 and 2 weeks (IV to subQ dosing) ☐ Every _____ weeks	☐ x1 year ☐ _____
Skyrizi (risankizumab)	**Initial infusion:** ☐ 600 mg or ☐ 1200mg IV at week 0, 4, and 8 weeks **Maintenance*:** ☐ 180mg or ☐ 360mg subQ at week 12, and every 8 weeks thereafter	☐ x1 year ☐ _____
☐ **Ustekinumab or ustekinumab biosimilar** (as required by patient's insurance)	**Initial infusion:** ☐ 260 mg or ☐ 390mg ☐ 520 mg IV x 1 dose **Maintenance*:** 90 mg SQ 8 weeks after initial inufsion and then every 8 weeks thereafter	☐ x1 year ☐ _____
Omvoh (mirikizumab)	**Initial infusion:** ☐ 300mg or ☐ 900mg IV at 0, 4, and 8 weeks **Maintenance*:** ☐ 200mg or ☐ 300mg subQ at week 12, then every 4 weeks	☐ x1 year ☐ _____
Tremfya (guselkumab)	**Initial infusion:** ☐ 200mg IV at 0, 4, and 8 weeks **Maintenance*:** ☐ 100mg subQ at week 16, then eveyr 8 weeks thereafter OR ☐ 200mg subQ at week 12, then every 4 weeks thereafter	☐ x1 year ☐ _____
☐ **Infliximab or infliximab biosimilar** (as required by patient's insurance)	**Dose:** _____ mg/kg IV **Frequency:** ☐ 0, 2, 6 then every 8 weeks ☐ Every _____ weeks	☐ x1 year ☐ _____

Premedication orders:
Acetaminophen ☐ 1000mg ☐ 500mg PO, *please choose one antihistamine:*
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IVP

Additional premedications:
☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____

Lab orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

☐ Yearly TB QFT ☐ Baseline HepBcAB total Required labs to be drawn by: ☐ US Infusions ☐ Referring Provider

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing US Infusions, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Signature: _____ **Date:** _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

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Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1).
- ☐ Include patient demographic information and insurance information.
- ☐ Include patient's medication list.
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance benefits, or contraindications to conventional therapy.
- ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., 6MP, azathioprine)? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Humira, Stelara, Cimzia)? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ Include labs and/or test results to support diagnosis.
- ☐ If applicable - Last known biological therapy: _____ and last date received: _____.
  If patient is switching biologic therapies, please perform a wash-out period of _____ weeks prior to starting ordered biologic therapy.
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)

- ☐ **TB screening test completed within 12 months - attach results** ☐ **Positive** ☐ **Negative**
  Required for: Cimzia, Infliximab, Stelara, Entyvio, Skyrizi, Omvoh, Tremfya

- ☐ **Hepatitis B screening test completed (Hepatitis B surface antigen) - attach results** ☐ **Positive** ☐ **Negative**
  Required for: Cimzia, Infliximab

- ☐ **Liver function tests & bilirubin Required for:** Skyrizi, Omvoh

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)