

Gastroenterology Enrollment Form

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Patient Weight: _____ lbs. (required) Address: _____

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

MEDICAL INFORMATION

Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other: _____

ICD-10 Code: _____

THERAPY ORDER

MEDICATION	ORDERS	REFILL	PRE-MEDICATIONS	LAB ORDERS
☐ Cimzia	☐ 400mg subQ at weeks 0, 2, 4 and then every 4 weeks ☐ _____mg subQ every _____ weeks		☐ Acetaminophen ☐ 500mg PO Please choose one antihistamine: ☐ Diphenhydramine ☐ 25mg PO ☐ 50mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO Additional Pre-medications: ☐ Solu-Medrol _____mg IVP ☐ Other: _____	☐ TB Screening Test* ☐ Cimzia ☐ Infliximab ☐ Stelara ☐ Entyvio ☐ Skyrizi ☐ Omvoh ☐ Tremfya ☐ Positive ☐ Negative ☐ Hep B Screening Test ☐ Cimzia ☐ Infliximab ☐ Positive ☐ Negative ☐ Liver Function Test & Bilirubin ☐ Skyrizi ☐ Omvoh *If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+) Home biologic IV Ana-kit (adult): Dispense EpiPen 0.3mg IM (2-pack) or compounded syringe, diphenhydramine 50mg IV and PO, NS 1000mL Home biologic injection Ana-kit (adult): EpiPen 0.3mg IM (2-pack)
☐ Infliximab or Infliximab Biosimilar	<i>As required by patient's insurance</i> ☐ Do not substitute. Infuse the following infliximab product: _____ ☐ For Internal Use Only. Brand: _____ Dose: _____mg/kg Frequency: ☐ Every _____ weeks OR ☐ 0, 2, 6 then every 8 weeks	☐ _____ ☐ x1 year		
☐ Skyrizi	Initial Dose: ☐ 600mg OR ☐ 1200mg IV at week 0, 4, and 8 weeks Maintenance: ☐ 180mg OR ☐ 360mg subQ at week 12 and every 8 weeks thereafter			
☐ Stelara	Initial Dose: ☐ <=55mg 260mg ☐ 55kg to 85kg 390mg ☐ >85kg 520mg IV x1 dose Maintenance: ☐ 90mg subQ 8 weeks after initial dose and then every 8 weeks			
☐ Entyvio	☐ 300mg IV at 0, 2, and 6 weeks and then Q8 weeks ☐ 300mg IV every 8 weeks ☐ 300mg IV at 0 and 2 weeks, <i>IV to subQ dosing</i>			
☐ Omvoh	Initial Dose: ☐ 300mg IV at 0, 4, and 8 weeks Maintenance: ☐ 200mg subQ at week 12, then 200mg subQ every 4 weeks			
☐ Tremfya	Initial Dose: ☐ 200mg IV at 0, 4, and 8 weeks Maintenance: ☐ 100mg subQ at week 16, then every 8 weeks thereafter OR ☐ 200mg subQ at week 12, then every 4 weeks thereafter			

PROVIDER INFORMATION

Provider Name: _____ Date: _____

NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

PRESCRIBER SIGNATURE

Prescriber's Signature: _____

Date: _____