GASTROENTEROLOGY ORDER FORM

PATIENT INFORMATION

Patient Name: _____

Address: _____

Primary Phone:_____ □ Home □ Cell □ Work

DOB: _____ Gender: □ Male □ Female

Allergies: _____

E-mail : _____

Patient weight :_____lbs Primary Language:_____

PRESCRIBER INFORMATION

Prescriber's Name: _____

State License # : _____ NPI # : _____

DEA # : _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Contact Person : _____ Phone : _____

□ Please fax copy of Demographics and insurance cards with this form, if available (front and back) □ Clinical/Progress Notes, Test supporting primary □ Labs

ORAL ORDERS

□ XIFAXAN 550	□ Take One tablet by Mouth twice a day	Quantity:_____	Refills:_____
□ ENTERAGAM	□ _____	Quantity:_____	Refills:_____

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	DURATION
□ **Dehydration** □ **Gastroenteritis** □ **Diverticulitis**	□ 1 Liter/ □ 2 Liters D5 45% NS IV x 1 day □ 1 Liter/ □ 2 Liters NS IV x 1 day □ **Cipro** 400mg IV daily x 1 day □ **Flagyl** 500mg IV daily x 1 day □ **Invanz** 1gm IV daily x 1 day	
□ **Iron Deficiency Anemia** □ **Iron Deficiency Anemia with CKD not on dialysis** Required Recent Labs: HGB, HCT, TIBC, Ferritin	□ **Venofer** 200mg IV q 3 weeks x 5 doses □ **Venofer** 100mg IV q week x 7 weeks then every other week x 7 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 1500mg *if patient weighing 50kg (110lbs) or greater*	
□ **Crohn's Disease** □ **Ulcerative Colitis**	□ **Cimzia** 400mg Subq at weeks 0,2,4 and then every 4 weeks □ **Cimzia** _____mg Subq every _____ weeks □ **Remicade** _____mg/kg every _____ weeks □ **Remicade** _____mg/kg on weeks 0,2,6 and then every 8 weeks Pre-Medication Orders: □ Tylenol 1000mg Antihistamine: □ Cetirizine 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 □ **Stelara** maintenance: □ 90mg Subq 8 weeks after initial and then every 8 weeks □ **Tysabri** 300mg every 4 weeks □ JCV antibody □ Patient TOUCH authorization □ **Entyvio** 300 mg IV over 30 minutes at 0,2,6 weeks and then Q8 weeks (baseline LFTs) □ **Entyvio** 300mg IV every 8 weeks	□ □ x 1 year

TB test: □ TB Test Attached □ Perform Tb testing **TB PROTOCOL**: Baseline testing: Quantiferon Gold (QFT Gold) or PPD.
Hepatitis B PROTOCOL: Hep B surface antigen and Hep B core AB total required.
****Date of last**: □ Orencia □ Remicade □ Humira or □ Enbrel Dose: _____ Date: _____

Physician Signature: X_____ □ **DAW (Dispense as Written) Date:** _____

By signing this document you authorize Southside pharmacy to contact insurance companies for prior authorization purposes.

FAX TO (855) - 822 - 7838

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