

**Gastroenterology Medication
Enrollment Form – Page 1 of 2**

TwelveStone Health Partners



Date: _____
Patient Name: _____
Date of Birth: _____

Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: _____ Next Infusion Date: _____	<input type="checkbox"/> Physician's Office <input type="checkbox"/> TwelveStone Infusion Suite <input type="checkbox"/> TwelveStone Home Infusion <input type="checkbox"/> Other: _____ Desired Start Date: _____

DIAGNOSIS

Description <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis	ICD-10 Code <input type="checkbox"/> K50.0 <input type="checkbox"/> K51.9
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OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

This signed order form
 History and Physical
 Tysabri Touch Authorization
 TB and Hep B Documentation
 Patient Demographics and Insurance Information
 Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg/Lbs Height: _____ Inches/CM Allergies: _____

Line Access: PIV PICC (SL DL TL) PORT (Huber size ____ Gauge ____ Length) Sub-Q

Currently Receiving and/or Prior Failed Therapies:	<input type="checkbox"/> NSAIDS <input type="checkbox"/> Methotrexate <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> 5-ASA <input type="checkbox"/> Azathioprine <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Mercaptopurine <input type="checkbox"/> Biologics: _____ <input type="checkbox"/> Other: _____ Length of Treatment: _____ Reason for Discontinuing or Adding Supplemental Tx: _____	Contraindicated Medications: Reason: _____
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MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
<input type="checkbox"/> Entyvio	300mg vial	<input type="checkbox"/> Initiation - Infuse 300mg IV over 30 minutes at week 0,2, and 6 <input type="checkbox"/> Maintenance - Infuse 300mg IV over 30 minutes every 8 weeks	<input type="checkbox"/> Baseline Liver Enzymes <input type="checkbox"/> TB Skin Test	
<input type="checkbox"/> Remicade	100mg Vial	<input type="checkbox"/> Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0,2 and 6 <input type="checkbox"/> Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> Hepatitis B protocol	
<input type="checkbox"/> Inflectra	100mg Vial	<input type="checkbox"/> Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0,2, and 6 <input type="checkbox"/> Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> Hepatitis B protocol	
<input type="checkbox"/> Renflexis	100mg Vial	<input type="checkbox"/> Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0,2, and 6 <input type="checkbox"/> Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> Hepatitis B protocol	
<input type="checkbox"/> Humira	<input type="checkbox"/> 40mg Pen <input type="checkbox"/> 80mg Pen	<input type="checkbox"/> Initiation - 1st dose inject 160mg SQ, then 2 weeks later inject 80mg SQ <input type="checkbox"/> Maintenance - Inject 40mg SQ every other week	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> Baseline CBC and q ____ thereafter	
<input type="checkbox"/> Cimzia	200mg/ml PFS	<input type="checkbox"/> Initiation - Inject 2ml (400mg - 2 syringes) SQ at weeks 0,2, and 4 <input type="checkbox"/> Maintenance - Inject 2ml (400mg - 2 syringes) SQ every 4 weeks	<input type="checkbox"/> TB Skin Test	
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg vial <input type="checkbox"/> 90mg PFS	<input type="checkbox"/> Initiation - < 55kg 260mg; 55-85kg 390mg; > 85kg 520mg IV infusion over 60 minutes x 1 dose <input type="checkbox"/> Maintenance - Inject 90mg SQ every 8 weeks	<input type="checkbox"/> TB Skin Test	
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100mg SmartJect <input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Initiation - Inject 200mg SQ (2 injections) at week 0, then 100mg at week 2, and then every 4 weeks <input type="checkbox"/> Maintenance - Inject 100mg SQ every 4 weeks	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> CBC with Diff	
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> Xeljanz 5mg <input type="checkbox"/> Xeljanz XR 11mg	<input type="checkbox"/> Take one tablet by mouth twice daily <input type="checkbox"/> Take one tablet by mouth daily		
<input type="checkbox"/> Difucid	200mg tablet	Take 1 tablet by mouth twice a day for 10 days		
<input type="checkbox"/> Xifaxan	550mg tablet	<input type="checkbox"/> Take 1 tablet by mouth twice daily <input type="checkbox"/> Take 1 tablet by mouth three times daily		
<input type="checkbox"/> Creon	<input type="checkbox"/> 3000, <input type="checkbox"/> 6000, <input type="checkbox"/> 12000, <input type="checkbox"/> 24000, <input type="checkbox"/> 36000	Take ____ capsules by mouth three times daily with meals and ____ capsules with snacks daily for a total of ____ capsules per day		
<input type="checkbox"/> Tysabri	300mg Vial	Infuse 300mg IV over 60 minutes every 4 weeks		

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Premedication(s):

- Diphenhydramine 25-50 mg po – 25mg #2 per dose
- Acetaminophen 325-650 mg po – 325mg #2 per dose
- Methylprednisolone _____mg IV over _____mins
- Other: _____

Ancillary Orders:

- NaCl 0.9% 5-10ml IV before and after infusion
- Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
- Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
- All infusion supplies necessary to administer the medication
- Anaphylaxis Kit

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers

Dispense as Written

Date

Substitution Allowed

Date

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