Gastroenterology Medication Enrollment Form – Page 1 of 2

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners
Fax Referral To:
(615) 278-3355
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: _____	☐ Physician's Office ☐ Ambulatory Infusion Suite ☐ Home Infusion ☐ Other: _____ Desired Start Date: _____

DIAGNOSIS

Description	*ICD-10 Code*
☐ Crohn's Disease	☐ K50.0
☐ Ulcerative Colitis	☐ K51.9

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:	☐ NSAIDS ☐ Methotrexate ☐ Sulfasalazine ☐ 5-ASA ☐ Azathioprine ☐ Corticosteroids ☐ Mercaptopurine ☐ Biologics:_____ ☐ Other: _____ Length of Treatment: _____ Reason for Discontinuing or Adding Supplemental Tx: _____	Contraindicated Medications: Reason: _____

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
☐ Entyvio	300mg vial	☐ Initiation - Infuse 300mg IV over 30 minutes at week 0,2, and 6 ☐ Maintenance - Infuse 300mg IV over 30 minutes every 8 weeks	☐ Baseline Liver Enzymes ☐ TB Skin Test	
☐ Remicade	100mg Vial	☐ Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0,2 and 6 ☐ Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Inflectra	100mg Vial	☐ Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0,2, and 6 ☐ Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Injectafer	750mg Vial	☐ < 50kg- Infuse 15mg/kg IV for 2 doses given at least 7 days apart. ☐ > 50kg- Infuse 750mg IV for 2 doses given at least 7 days apart.		
☐ Humira	☐ 40mg Pen ☐ 80mg Pen	☐ Initiation - 1st dose inject 160mg SQ, then 2 weeks later inject 80mg SQ ☐ Maintenance - Inject 40mg SQ every other week	☐ TB Skin Test ☐ Baseline CBC and q ___ thereafter	
☐ Cimzia	200mg/ml PFS	☐ Initiation - Inject 2ml (400mg - 2 syringes) SQ at weeks 0,2, and 4 ☐ Maintenance - Inject 2ml (400mg - 2 syringes) SQ every 4 weeks	☐ TB Skin Test	
☐ Stelara	☐ 130mg vial ☐ 90mg PFS	☐ Initiation - < 55kg 260mg; 55-85kg 390mg; > 85kg 520mg IV infusion over 60 minutes x 1 dose ☐ Maintenance - Inject 90mg SQ every 8 weeks	☐ TB Skin Test	
☐ Simponi	☐ 100mg SmartJect ☐ 100mg PFS	☐ Initiation - Inject 200mg SQ (2 injections) at week 0, then 100mg at week 2, and then every 4 weeks ☐ Maintenance - Inject 100mg SQ every 4 weeks	☐ TB Skin Test ☐ CBC with Diff	
☐ Xeljanz	☐ Xeljanz 5mg ☐ Xeljanz XR 11mg	☐ Take one tablet by mouth twice daily ☐ Take one tablet by mouth daily		
☐ Dificid	200mg tablet	Take 1 tablet by mouth twice a day for 10 days		
☐ Xifaxan	550mg tablet	☐ Take 1 tablet by mouth twice daily ☐ Take 1 tablet by mouth three times daily		
☐ Creon	☐3000, ☐6000, ☐12000, ☐24000, ☐36000	Take ___ capsules by mouth three times daily with meals and ___ capsules with snacks daily for a total of ___ capsules per day		
☐ 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.

Physician's Phone#	Physician's NPI#	Physician's Fax#	Physician's Address

Dispense as Written	Date	Substitution Allowed	Date