Gastroenterology Medication Enrollment Form

Enrollment Form - Page 1 of 2

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

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: _____	☐ 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 ___mg/kg IV over 2-3 hours at week 0,2 and 6 ☐ Maintenance - Infuse ___mg/kg IV over 2-3 hours every 8 weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Inflectra	100mg Vial	☐ Initiation - Infuse ___mg/kg IV over 2-3 hours at week 0,2, and 6 ☐ Maintenance - Infuse ___mg/kg IV over 2-3 hours every 8 weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Renflexis	100mg Vial	☐ Initiation - Infuse ___mg/kg IV over 2-3 hours at week 0,2, and 6 ☐ Maintenance - Infuse ___mg/kg IV over 2-3 hours every 8 weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Injectafer	750 mg vial	☐ < or =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/0.8ml Pen and PFS ☐ 40mg/0.4ml CF Pen and PFS ☐ 40mg/0.8ml Pen Starter Pack for CD/UC/HS	☐ Initiation (Pediatric 17kg to <40kg) -1st dose inject 80mg SQ, then 40 mg on Day 15, and 20mg on Day 29	☐ TB Skin Test ☐ Baseline CBC and q ___ thereafter	
	☐ 40mg/0.4ml CF Pen Starter Pack for CD/UC/HS ☐ 80mg/0.8ml CF Pen Starter Pack for CD/UC/HS ☐ 80mg/0.8ml CF PFS Pediatric Crohn's Disease Starter Pack ☐ 40mg/0.8ml PFS Pediatric Crohn's Disease Starter Pack	☐ Initiation (Adult and pediatric > or =40kg) -1st dose inject 160mg SQ, then 80mg on Day 15		
	☐ 80mg/0.8ml and 40mg/0.4ml PFS Pediatric Crohn's Disease Starter Pack ☐ 20mg/0.4ml PFS ☐ 20mg/0.2ml CF PFS	Maintenance – Inject _____mg SQ every other week		
☐ Cimzia	☐ 200mg vial ☐ 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	

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MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
☐ Simponi	☐ 100mg SmartJect	☐ Initiation - Inject 200mg SQ (2 injections) at week 0, then 100mg at week 2, and then every 4 weeks	☐ TB Skin Test ☐ CBC with Diff	
	☐ 100mg PFS	☐ Maintenance - Inject 100mg SQ every 4 weeks		
☐ Xeljanz	☐ Xeljanz 5mg	☐ Take one tablet by mouth twice daily		
	☐ Xeljanz 10mg			
	☐ Xeljanz XR 11mg	☐ Take one 22XR tablet by mouth daily for 8 weeks		
	☐ Xeljanz XR 22mg	☐ Take _____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		

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