CarePartners Specialty Infusion

Gastroenterology IV Infusion Enrollment Form

Fax Referral To: 866-832-7180
Phone: 866-852-0202

To better serve your patient and facilitate insurance authorization, please attach the following:

- **Patient demographics, H&P, and labs**
- **The front and back of insurance & prescription drug card**

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

CLINICAL INFORMATION

DIAGNOSIS:

☐ K50.00 Crohn's Disease
☐ K51.90 Ulcerative Colitis
☐ Other: _____

Requested Therapy Start Date: _____
Prior Medication Failed: _____
Length of Failed Treatment: _____
Reason for Discontinuation: _____

PATIENT EVALUATION:

TB/PPD Test: ☐ Positive ☐ Negative Date Read: _____
Hepatitis B virus screening result: ☐ Positive ☐ Negative Date Read: _____
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____ ☐ NKDA
Pharmacy to coordinate home health nursing visit: ☐ Yes ☐ No
If home health nursing coordination not necessary, please indicate reason:
☐ MD office or infusion center to administer to patient
☐ Home health nursing already coordinated

PRESCRIPTION INFORMATION

MEDICATION	DOSE AND DIRECTIONS	QUANTITY DISPENSE	REFILLS
☐ Entyvio®	☐ Induction dose: Infuse 300mg IV at weeks 0, 2, and 6	Dispense weeks 0, 2, 6	NONE
	☐ Maintenance dose: Infuse 300mg IV every _____ weeks ***Pharmacy to provide post-Entyvio infusion 30ml flush of normal saline***	Qty: _____ vials *1 vial = 300mg*	_____
☐ Inflectra® ☐ Remicade® ☐ Renflexis®	☐ Dose: _____mg ☐ 3 mg/kg ☐ 5 mg/kg ☐ 10 mg/kg ☐ Induction dose: Infuse _____mg IV at weeks 0, 2, & 6 ☐ Maintenance dose: Infuse _____mg IV every _____weeks ***Pharmacist to round to the nearest 100mg, using actual body weight to calculate, unless otherwise indicated here:** ☐ **Give exact dose (do NOT round)**	Dispense weeks 0, 2, 6 Qty: _____ vials *1 vial = 100mg*	NONE _____
☐ Skyrizi	Induction Dose: Infuse 600mg IV at weeks 0, 4, and 8.	Dispense weeks 0, 4, 8	NONE
☐ Stelara®	Induction Therapy: ☐ For patient weighing ≤55kg: Infuse 260mg as a one time IV infusion ☐ For patients weighing 56-85kg: Infuse 390mg as a one time IV infusion ☐ For patients weighing >85kg: Infuse 520mg as a one time IV infusion	1 cycle	NONE
☐ Other:	_____	_____	_____

REQUIRED for HOME INFUSION

To be infused via peripheral IV access, unless otherwise indicated. ☐ PORT ☐ PICC *****Flushes to be provided per CarePartners protocol on page 2***

DELIVERY METHOD: To be infused via gravity infusion, unless otherwise indicated ☐ MD prefers Infusion Pump

HYDRATION: Please select only if needed
☐ 0.9% NaCl _____ ml infused over _____ minutes
☐ D5W _____ ml infused over _____ minutes

*To be infused pre-infusion, unless otherwise specified below.
☐ Post-Infusion
☐ Concurrently with infusion

☐ **MD agrees that the order is to be infused per CarePartners Infusion protocols on page 2.**
- OR -
☐ **MD has made adjustments to CarePartners Infusion protocols on page 2, and agrees to the remaining unadjusted protocols.**

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____

☐ Dispense as Written
☐ Product Substitution Permitted

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CarePartners Specialty Infusion Protocols

FLUSH PROTOCOL: to be provided for IV drug administration days only.

- 0.9% NaCl: 1-5ml intravenous (peripheral line) or 10ml intravenous (central line) before/after infusion, or as needed for line patency/SASH.
- Heparin 10 units/ml: 5ml intravenous (peripheral line) as needed for final flush.
- Heparin 100 units/ml: 5ml intravenous (central line) as needed for final flush.

PREMEDICATIONS: to be given 30 minutes prior to infusion *(PLEASE STRIKE THROUGH IF NOT REQUIRED)*

Diphenhydramine 25mg-50mg by mouth
For pediatric diphenhydramine patients:

- <2 years old: 1mg/kg up to max 6.25mg po
- 2-5 years old: 6.25mg-12.5mg po
- 6-12 years old: 12.5mg-25mg po

Acetaminophen 325mg-650mg by mouth
For acetaminophen patient's weighing < 60kg:
10-15mg/kg po

MEDICATIONS to be used as needed/requested by patient/nurse *(PLEASE STRIKE THROUGH IF NOT REQUIRED)*

- Diphenhydramine: May repeat premedication dose every 4-6 hours as needed. Adult max: 100mg/day.
- Acetaminophen: May repeat premedication dose every 4-6 hours as needed. Adult max: 3000mg/day.
- Lidocaine 2.5%/Prilocaine 2.5% topical (may dispense Lidocaine 4%) to injection sites at least 1 hour prior to needle insertion.

ANAPHYLAXIS PROTOCOL: Pharmacy to provide the following as needed for anaphylactic reaction:

- Diphenhydramine 25mg- 50mg PO as needed for mild-moderate reaction. qty: 2
- Diphenhydramine 25mg- 50mg via slow IV push as needed for moderate-severe reaction. qty: one 50mg/ml vial
- Sodium Chloride 0.9% 500ml bag IV PRN for anaphylactic reaction. qty: 500ml
- Epinephrine 0.3mg (patient's weighing ≥ 30kg/66lbs)
- Epinephrine 0.15mg (patient's weighing between 15-30kg/33-66lbs)

Administer intramuscularly PRN severe allergic reaction.
Call 911. May repeat x 1.

RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling.

ADDITIONAL ORDERS: