

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
GASTROENTEROLOGY ORDER FORM

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	STAT	REFERRAL	

HT:in WT:kg Sex:( ) Male ( ) Female Allergies: ( ) NKDA,	HT:	get Nam	TINFORMATION ne:			Firet Name:			MI D∩R∙	
Physician Name	Physician Name Contact Name Contact Phone #									
STATEMENT OF MEDICAL NECESSITY   Tax   D#:   Fax #:	NPI #	пт	III W1 kg	Sex .( ) ividie	( ) Felliale 7	Allergies. ( ) INNDA,				
STATEMENT OF MEDICAL NECESSITY   Tax   D#:   Fax #:	NPI #:	Physician	n Name			Contact Name		Conta	ct Phone #	
STATEMENT OF MEDICAL NECESSITY Primary Diagnosis: ICD-10 Code plus Description: PERTINENT MEDICAL HISTORY  Does patient have venous access?   YES   NO If yes, what type   MEDIPORT   PIV   PICC LINE   OTHER:  1) TB test performed? O Yes O No Date: Results.  2) Patient diagnosed with Congestive Heart Failure? O Yes O No 3) Liver function test normal? O Yes O No 4) Patient previously treated with Entyvio OR Remicade OR Simponi Aria? O Yes O No Please select: O Entyvio O Remicade O Simponi Aria Date:  5) Hep-B antigen surface antibody test? O Yes O No Date: PRESCRIPTION OR ORGERS:  9) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL  1) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY  9) DOSES MAYE ROUNDED TO NEAST YIAL SIZE WITHIN 10% OF PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN UNLESS WEIGHT CHANGES v/- BY	STATEMENT OF MEDICAL NECESSITY									
1) TB test performed? O Yes O No Date: Results	1) TB lest performed? O Yes O No Date: Results	Primary D	Diagnosis: ICD-10 Code plus [							
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4) Patient previously treated with Entyvio OR Remicade OR Simponi Aria? O Yes O No Please select: O Entyvio O Remicade O Simponi Aria Date:	4) Patient previously treated with Entyvio OR Remicade OR Simponi Aria? O Yes O No Please select: O Entyvio O Remicade O Simponi Aria Date:    5) Hep-B antigen surface antibody test? O Yes O No Date:	1) TB test	t performed? O Yes O No [	)ate:	Resu	ults,				
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PRESCRIPTION ORDERS: a) ALL MEDIPORTS / IN ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY c) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN UNLESS WEIGHT CHANGES +/- BY	PRESCRIPTION ORDERS:  a) ALL MEDIPORTS // N ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL  b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY  c) DOSES MAY SE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN UNLESS WEIGHT CHANGES +/- BY	4) Patient	t previously treated with Entyv	io OR Remicade	e OR Simponi A	ria? O Yes O No Ple	ease select: O E	Entyvio O Remicade O Simp	oni Aria Date:	
b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY c) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN UNLESS WEIGHT CHANGES +/- BY % d) BIOSIMILAR EQUIVILENT RENFLEXIS SUBSTITUTION MAY APPLY  ELECT DOSING OPTIONS DOSE ROUTE FREQUENCY (POPULATE BELOW) DURA	b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY e) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN UNLESS WEIGHT CHANGES #/- BY			? O Yes O No	Date:					
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DOSING OPTIONS	DOSING OPTIONS	•				SCRIBED DOSE. WEIC	GHT BASED DOS	ING WILL REMAIN UNLESS WER	GHT CHANGES +/- BY %	
ENTYVIO (LOADING DOSES)   300 mg	ENTYVIO (LOADING DOSES)   300 mg	u) biooiivii	ILAN EQUIVILENT NEW LEXIS C	IODOTTI OTION W.	AIAIILI					
ENTYVIO (MAINTENANCE DOSE)   300 mg	ENTYVIO (MAINTENANCE DOSE)   300 mg	ELECT	DOSING OPTIO	NS		DOSE	ROUTE	FREQUENCY (	POPULATE BELOW)	DURAT
RENFLEXIS (LOADING DOSES)   mg / kg	RENFLEXIS (LOADING DOSES)   mg / kg		ENTYVIO (LOADING DOS	ES)	300 mg		IV	0, 2, 6 WEEKS, THEN ON	CE EVERY 8 WEEKS	
RENFLEXIS (MAINTENANCE DOSES)   mg / kg   IV   ONCE EVERY   WEEKS	RENFLEXIS (MAINTENANCE DOSES)   mg / kg		ENTYVIO (MAINTENANCE	DOSE)	300 mg		IV	ONCE EVERY 8 WEEKS		
DTHER:   mg / kg   IV   ONCE EVERY   WEEKS	DTHER:   mg / kg   IV   ONCE EVERY   WEEKS		RENFLEXIS (LOADING DO	OSES)	mg / kg		0, 2, 6 WEEKS, THEN ON	CE EVERY WEEKS		
PREMEDS	PREMEDS		RENFLEXIS (MAINTENAN	CE DOSES)		mg / kg	IV	ONCE EVERY W	EEKS	
SELECT	SELECT   MEDICATION   DOSE   ROUTE   NONE   NA   NA   NA   NA   NA   NA   NA		OTHER:			mg / kg	IV	ONCE EVERY W	EEKS	
SELECT	SELECT   MEDICATION   DOSE   ROUTE   NONE   NA   NA   NA   NA   NA   NA   NA									
NONE	NONE			1.						
ACETAMINOPHEN   CMP   ( ) PRIOR ( ) POST	ACETAMINOPHEN   CMP   ( ) PRIOR ( ) POST			DOSE	ROUTE	SFLECT		AB REQUESTED	WHEN	FREQU
OXYGEN         BUN/CREATININE         ( ) PRIOR ( ) POST           SOLU-MEDROL         CRP         ( ) PRIOR ( ) POST           Other:         ESR         ( ) PRIOR ( ) POST           Other:         ALT         ( ) PRIOR ( ) POST           Other:         AST         ( ) PRIOR ( ) POST           Other:         LIVER PANEL         ( ) PRIOR ( ) POST           Other:         VECTRA         ( ) PRIOR ( ) POST	OXYGEN         BUN/CREATININE         ( ) PRIOR ( ) POST           SOLU-MEDROL         CRP         ( ) PRIOR ( ) POST           Other:         ESR         ( ) PRIOR ( ) POST           Other:         ALT         ( ) PRIOR ( ) POST           Other:         AST         ( ) PRIOR ( ) POST           Other:         LIVER PANEL         ( ) PRIOR ( ) POST           Other:         VECTRA         ( ) PRIOR ( ) POST           Other:         OTHER:         ( ) PRIOR ( ) POST	.ECT	MEDICATION				L	AB REQUESTED		FREQU NA
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