Crohn's Disease/Ulcerative Colitis Prescription / Enrollment Form

Date: _____

Y Medical Associates
Fax Referral To: 855-838-0623
Phone: 800-447-7558

YMedical ASSOCIATES

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

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

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

MEDICAL INFORMATION

Patient Weight: _____
Allergies: _____
Diagnosis, ICD10: _____

☐ Clinical/Progress Note, Labs, Tests supporting primary diagnosis are attached.

PRE-SCREENING

Please include most recent clinical notes and lab results for the following:

☐ Hep B surface antigen and Hep B Core AB total required (Cimzia, Infliximab) ☐ Baseline TB Testing or PPD (Cimzia, Infliximab, Stelara, and Entyvio)
☐ CMP (Entyvio, Stelara)

PRESCRIPTION ORDERS

Premeds

Premedication to be given 30 minutes prior to infusion:

☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg
☐ Diphenhydramine: ☐ 25mg IVP ☐ 50mg IVP ☐ 25mg PO ☐ 50mg PO **OR** ☐ Alternate oral antihistamine: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mgs ☐ Fexofenadine 180mgs
☐ Others/Miscellaneous: _____

Anaphylaxis:

☐ Epinephrine pen Auto-Injector 2 pack 0.3mg/0.3ml IM as needed for anaphylaxis

Medication

☐ **Infliximab**, Brands: ☐ Inflectra ☐ Remicade ☐ Renflexis ☐ Avsola
Dose: _____ mg/kg
Frequency: ☐ Every _____ weeks OR
☐ 0, 2, 6 then every 8 weeks

☐ **Entyvio**: 300mg IV over 30 minutes at 0,2,6 weeks and then every 8 weeks (baseline LFTs)

☐ **Entyvio**: 300 mg IV every 8 weeks

☐ **Stelara**: Initial Infusion ☐ <55kg 260mg IV over 1 hour x 1 dose
☐ 55kg to 85kg 390mg IV 1 hour x 1 dose
☐ >85 kg 520mg IV 1 hour x 1 dose

☐ **Stelara**: Maintenance: ☐ 90 mg SQ 8 weeks after initial infusion and then every 8 weeks

Flushing Protocol: ☐ NaCl 0.9% 5-10ml IV before and after infusion
☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral/PICC access and PRN
☐ Heparin 100units/ml 3-5ml IV after infusion for Port IV access and PRN

☐ All infusion supplies necessary to administer the medication *Skilled nurse to assess, teach, and administer prescribed medication and admit for services.*

To be infused at: ☐ Home ☐ Infusion Suite ☐ MD Office (to be monitored by a healthcare professional)

LAB Monitoring: Labs required to be drawn by : ☐ Infusion Clinic ☐ Referring Physician

☐ Lab Orders: _____

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

_____ _____ _____ _____
Dispense as Written Date Substitution Allowed Date