

Specialty Injections Order Form Crohns and Colitis



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Prescriber's Name: _____ MD / DO / NP / PA
Address: _____
City _____ State _____ Zip _____
Office Contact: _____ Phone# _____ Fax# _____
NPI: _____ DEA: _____ License: _____

PATIENT INFORMATION

Send updates to Fax E-mail to _____ Text to Phone# _____

Patient's Name: _____ SS# _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work or Cell: _____ Emergency Contact: _____

Allergies: _____ Sex: M ___ F ___ Wt: _____ Ht: _____ Diabetic: Y ___ N ___

Patient previously on treatment: Y ___ N ___ Date: _____

Primary Insurance: _____ Policy# _____

Insured: _____ Group _____

Phone: _____ BIN# _____ PCN# _____

*** Please include current patient medication list with referral ***

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: 555.0 Crohns 556.9 Ulcerative Colitis Other _____ Date of Diagnosis: _____

Allergies: NKDA

Height: in cm Weight: lbs kgs Date: _____
TB Status: Active TB PPD (-) date: _____ last CXR date: _____ unknown

DNR Status: Rc'd N/A

Did patient receive other medical therapies in the last 6 mos.? No Yes, Date: _____

Medical History: Diabetes Current Active Infection Pt lives in a region endemic for Immunizations up to date
 Heart Failure Malignancy bacterial, mycobacterial or Other: _____
 CNS Disorder Immunosuppressive Therapy fungal infection _____

TREATMENT ARRANGEMENTS

Ship Meds: _____ Teaching by: Special Design Healthcare Drs. Office Other _____

Home Doctors Office Infusion by: Special Design Healthcare Drs. Office Other _____

Is this the first dose? Yes No If no, date first dose given: _____ start ASAP Next dose due: _____

ADALIMUMAB (Humira®) PEN

28 Day Supply

CROHNS STARTER KIT
160mg (4 Pens) SubQ on day 1, then 80mg (2 Pens) on day 15 then on day 29 begin maintenance dosing.

MAINTENANCE
40mg (1 Pen) SubQ every 14 days
 Other regimen: _____
Refills x _____

INFLIXIMAB (Remicade®)

56 Day Supply

Infuse 5mg/kg IV in 250ml NSS over 2 hrs at wk 0, 2, 6 and then every 8 wks.
 Exact Dose
 Round Dose up or down to nearest 100mg
* Titrated infusion rate will be used unless otherwise noted: 10ml/hr x 15min; 20ml/hr x 15min; 40ml/hr x 15min; 80ml/hr x 15min; 150ml/hr x 30min; 250 ml/hr x 30min
 Other infusion regimen _____
 Normal Saline 10ml Pre-filled Syringe
10ml before & after IV infusion and as needed
* QS for each infusion
Refills x _____

CERTOLZIFUMAB PEGOL (Cimzia®)

28 Day Supply

400 mg SQ. on Weeks 0, 2, 4 and then every 4 weeks
Refills x _____

NATALIZUMAB (Tysabri®)

28 Day Supply

Infuse 300 mg IV over 1 hour every 4 weeks
***must be enrolled in TOUCH CD program**
 Normal Saline 10ml Prefilled Syringe
10ml before & after IV infusion and as needed
*QS for each infusion
Refills x _____

Other Orders:

Premedications

* Given 30 minutes before infusion *
 Diphenhydramine (Benadryl®) 25mg Orally given 30 minutes before infusion x1
 Acetaminophen (Tylenol®) 650 mg Orally given 30 min before infusion x1
 Methylprednisolone (Solu-Medrol®) _____ mg IV x1
Authorized x1 year

Adverse Reactions

Acetaminophen (Tylenol®) 650 mg ORALLY for fever or mild discomfort. X1
 Diphenhydramine (Benadryl®) 50 mg ORALLY for mild to moderate allergic reactions x1
 EPI-PEN (1:1,000) 0.3ml IM for anaphylactic reactions and contact 911.
Authorized x1 year

By signing this form and utilizing our services, you are authorizing SDHC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: _____

May Substitute

Dispense as Written

Date: _____