Arthritis & Osteoporosis Center, LLC

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Gastroenterology Infusion Order

Patient name____DOB______________________

Phone number_______________________________________ Weight_____________________

Diagnosis: Crohn's K50.90______ UC K51.90______ Other diagnosis ______________________

Required labs for all infusions HBsAG, anti-HBsAB, anti HBc, QTB/PPD/T-spot, HIV. Add Anti-JCV for Tysabri.

Gastroenterology

______ Entyvio 300 mg IV on week 0, 2, 6, then every 8 weeks

______ Tysabri 300 mg IV every 4 weeks

______ Infliximab Induction ____ 3 mg/kg= _____mg IV on week 0, 2, 6

____ 5 mg/kg= _____mg IV on week 0, 2, 6

Maintenance ____ mg/kg= ______mg IV on week 0, 2, 6

______ Stelara initial weight based IV once _____ < 55 kg 260 mg _____ 55-85 kg 390 mg _____ >85 kg 520 mg

______ Skyrizi 600 mg IV on week 0, 4, 8

______ Cimzia 400 mg SQ week 0, 2, 4 and every 4 weeks thereafter.

Pre Meds given PRN

___ Diphenhydramine 25mg/50mg (circle one) IV/PO ___ Solu-Medrol 40mg IV ___ Acetaminophen 650mg PO

______ Other or additional instructions____
____

Is this a new treatment for this patient_______________ or continuing treatment__________________

Prior tried and failed medications____

Contact person________________________________ Phone number____________________________

Name of ordering provider____

Ordering provider signature____ Date_____________

Order valid for one year.

Please fax this information, required test, last two office notes, and insurance cards to infusion coordinator 302-613-4697. Infusion coordinator can be reached at 302-483-7053.

Additional forms may be found on our website at Arthritisde.com.