GASTROENTEROLOGY ENROLLMENT FORM

APEXInfusion Ph. (877) 501-6800 F. (877) 501-6844

Date: / /

Patient Name:_____ DOB: / / Height:_____ Weight:_____

Ship to:
- ☐ Patient
- ☐ MD Office
- ☐ AIS Location:_____

Allergies:_____ Email:_____

Address:_____ Ph:_____

Prescriber:_____ Ph:_____ Fax:_____

PLEASE ATTACH ORIGINAL PRESCRIPTION ORDERS & FAX THE FOLLOWING:

- Patient demographics
- Face sheet
- Insurance information
- Labs
- Additional labs: CBC, CMP, CRP/ESR
- Endoscopy or colonoscopy, if applicable
- H&P
- Medications and therapies tried and failed
- Baseline assessment, including detailed patient symptoms

DIAGNOSIS

☐ K50.90 - Crohn's disease, unspecified ☐ K51.9 - Ulcerative colitis, unspecified ☐ Other (ICD-10 required):_____

Hep B/Hep C Test: ☐ Positive ☐ Negative

TB/PPD Test: ☐ Positive ☐ Negative

Injection Training or Home Health RN visit is necessary: ☐ Yes ☐ No

Prior medication failed:_____

Length of treatment:_____

Reason for discontinuation:_____

MEDICATION ORDER	ADMINISTRATION
☐ **Entyvio®** (vedolizumab)	☐ **Initial:** Infuse 300mg IV over 30 minutes at day 0, 14, and 42. ☐ **Maintenance:** Infuse 300mg IV over 30 minutes every 8 weeks. Refills x 1 year.
☐ **Inflectra®** (infliximab-dyyb) ☐ **Infliximab** (infliximab) ☐ **Remicade®** (infliximab) ☐ **Renflexis®** (infliximab-abda)	☐ **Initial:** Infuse IV _____ mg per kg (Dose _____ mg) at 0, 2, and 6 weeks. ☐ **Other:**_____ ☐ **Maintenance:** Infuse IV _____ mg per kg (Dose _____ mg) every _____ weeks. Refills x 1 year. Pharmacy to dispense to nearest 100mg vial. **Patient to infuse exact dose (do NOT round).**
☐ **Simponi®** (golimumab)	☐ **Initial:** Inject 200mg SUBQ on day 0, then 100 mg on day 14. ☐ **Maintenance:** Inject 100mg SUBQ every 4 weeks. Refills x 1 year.
☐ **Skyrizi®** (risankizumab-rzaa)	**IV Induction Dosing Only** ☐ **Crohn's Disease:** 600mg administered by IV infusion over at least one hour at weeks 0, 4, and 8. ☐ **Ulcerative Colitis:** 1200mg administered by IV infusion over at least two hours at weeks 0, 4, and 8. **SUBQ (Maintenance Dose):** ☐ **Prefilled cartridge:** ☐ 180mg ☐ 360mg administered at week 12 and every 8 weeks thereafter. Refills x 1 year.
☐ **Stelara®** (ustekinumab)	☐ **Initial (Weight-Based Dosing, IV Infusion, Single Dose):** ☐ Up to 55 kg: 260 mg (2 vials) ☐ 55-85 kg: 390 mg (3 vials) ☐ Over 85 kg: 520 mg (4 vials) ☐ **Maintenance:** Inject 90mg SUBQ 8 weeks after initial dose, then every 8 weeks thereafter. Refills x 1 year.
☐ **Tremfya®** (guselkumab)	☐ **Crohn's Disease or Ulcerative Colitis (Initial):** 200mg IV on weeks 0, 4, and 8. ☐ **Crohn's Disease (Initial SUBQ Option):** 400mg SUBQ (as 2 consecutive 200mg injections) on weeks 0, 4, and 8. ☐ **Crohn's Disease or Ulcerative Colitis (Maintenance):** 100mg SUBQ at week 16, then every 8 weeks thereafter. Refills x 1 year. ☐ **Crohn's Disease or Ulcerative Colitis (Maintenance):** 200mg SUBQ at week 12, then every 4 weeks thereafter. Refills x 1 year.

☐ **Other:**

PRE-MEDICATION ORDERS & OTHER MEDICATIONS

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.

Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

☐ Acetaminophen _____ mg PO prior to infusion

☐ Diphenhydramine _____ mg ☐ PO ☐ IV

☐ Methylprednisolone _____ mg IV

☐ Hydration: Solution _____ volume _____ to be infused ☐ Pre OR ☐ Post

☐ Other:_____