Gastroenterology Infusion

Referral Form

Email: intake@infuseoneohio.com
Fax: (614) 929-7199

INFUSE ONE OHIO

PLEASE ATTACH INSURANCE CARDS - FRONT AND BACK

☐ Dublin, OH ☐ Lancaster, OH

PATIENT INFORMATION

Last Name, First Name | **Date of Birth** | **Gender** ☐ M ☐ F

Address | **City, State, ZIP** | **Phone**

REFERRING PROVIDER INFORMATION

Referring Practice | **Practice Address / City / State / ZIP**

Prescriber Name | **Prescriber NPI** | **Nurse / Key Contact** | **Phone**

Fax | **Email**

INSURANCE INFORMATION

PRIMARY **Insurance Plan** | **Policy #** | **Plan ID**

Secondary Insurance Plan | **Secondary Policy #** | **Secondary Plan ID**

DIAGNOSIS & CLINICAL INFORMATION

Attach clinical/progress notes, labs, tests, and supporting diagnosis

☐ Crohn's Disease **Diagnosis Code**

☐ Ulcerative Colitis **Diagnosis Code**

☐ Other

Currently received and/or prior failed therapies

Length of treatment | **Reason for discontinuation**

TB/PPD Test ☐ Positive ☐ Negative **Date**

☐ Allergies

☐ NKDA **Height** **Weight**

Site of Care ☐ Home ☐ AIC ☐ Other

PRESCRIPTION INFORMATION

MEDICATION	DOSE / STRENGTH	DIRECTIONS	REFILLS
☐ Entyvio (vedolizumab)	☐ 300 mg vial	☐ INITIAL: Infuse 300 mg IV at weeks 0, 2, 6, then every 8 weeks ☐ MAINTENANCE: Infuse 300 mg IV every ____ weeks	
☐ Infliximab ☐ Remicade ☐ Renflexis ☐ Inflectra	☐ 100 mg vial	☐ INITIAL: Infuse ____ mg/kg IV at weeks 0, 2, 6, then every 8 weeks ☐ MAINTENANCE: Infuse ____ mg/kg IV every ____ weeks ☐ Other ____ ☐ Round to nearest 100 mg ☐ Give exact dose - do NOT round	
☐ Stelara (ustekinumab)	☐ 130 mg / 26 mL vial ☐ 90 mg (2 x 45 mg)	☐ INITIAL: Weight-based IV infusion ☐ 55 kg or less: 260 mg (2 vials) ☐ 55-85 kg: 390 mg (3 vials) ☐ Greater than 85 kg: 520 mg (4 vials) ☐ MAINTENANCE: 90 mg SQ 8 weeks after initial dose, then every 8 weeks	
☐ Skyrizi (risankizumab)	☐ 600 mg / 10 mL ☐ 1200 mg / 20 mL	☐ INITIAL: 600 mg/10 mL or 1200 mg/20 mL IV at weeks 0, 4, and 8 ☐ MAINTENANCE: Inject SQ at week 12, then every 8 weeks	
☐ Tremfya (guselkumab)	☐ 200 mg / 20 mL IV ☐ 100 mg SQ ☐ 200 mg SQ	☐ INITIAL: Infuse 200 mg IV over at least 1 hour at weeks 0, 4, and 8 ☐ MAINTENANCE: 100 mg SQ at week 16, then every 8 weeks ☐ OR 200 mg SQ at week 12, then every 4 weeks	

PRE-MEDICATION & OTHER MEDICATIONS

☐ Acetaminophen ____ mg PO prior to infusion

☐ 250 mL 0.9% NaCl for hydration

Infusion supplies and anaphylaxis kit per protocol.

☐ Diphenhydramine ____ mg ☐ PO ☐ IV

☐ Other

FLUSH: NaCl 0.9% 10 mL before and after infusion.

AUTHORIZATION, SIGNATURE & REQUIRED ATTACHMENTS

I authorize Infuse One Ohio to initiate required insurance prior authorization for this prescription and future refills. I may revoke this designation at any time by written notice.

Physician Signature | **Date**

☐ Patient demographics

☐ Medical insurance card - front/back

☐ Pharmacy card - front/back, if available

☐ Most recent chart notes, diagnostic testing, and labs

☐ Proof of concurrent treatment with other biologics