

# GASTROENTEROLOGY ENROLLMENT FORM

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\* Patient Name: \_\_\_\_\_ DOB: / / Height: \_\_\_\_\_ Weight: \_\_\_\_\_ kg Date: / /  
 Allergies: \_\_\_\_\_ Email: \_\_\_\_\_ Sip to: A Patient  
 Address: \_\_\_\_\_ Ph: \_\_\_\_\_ \* Prescriber Signature MD Office  
 \* Prescriber: \_\_\_\_\_ Ph: \_\_\_\_\_ Fax: \_\_\_\_\_ Altea Location: A  
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DOCUMENTS TO INCLUDE WITH REFERRAL	DIAGNOSIS
<ul style="list-style-type: none"> <li>* Patient demographics</li> <li>* Copies of insurance card (front and back)</li> <li>* Pharmacy Card</li> <li>* <b>Recent Lab Results:</b> Antibody panel, BUN/SCr, IgA level, and EMG/NCV studies</li> <li>* Specialist consults and recent progress notes</li> <li>• Prior medications and therapies (failed or inadequate response)</li> <li>• Relevant imaging studies (MRI, CT, X-ray, etc.)</li> <li>• Baseline functional assessment with detailed symptom history</li> </ul>	<p>K50.00 Adult Crohn's Disease                      K51.90 Adult Ulcerative Colitis                      K50.00 Pediatric Crohn's Disease                      K76.82 Hepatic Encephalopathy                      Other _____</p> <p>Hep B/Hep C Test:    Positive    Negative            TTB/PPD:    Positive    Negative                      Injection Training or Home Health RN visit is necessary:    Yes    No</p> <p>Prior Medication Failed: _____                      Length of Treatment: _____                      Reason for Discontinuation: _____</p>

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

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

Premedications & Other Medications - Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

Acetaminophen \_\_\_\_\_ mg PO prior to infusion      Diphenhydramine \_\_\_\_\_ mg PO      Other: \_\_\_\_\_