



Clinical Specialty Infusions, LLC

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

REMICADE/ENTYVIO/STELARA ENROLLMENT FORM

Account manager: _____

Contact info: _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Patient/Caregiver (if applicable):			
Address:		City:	State:	Zip:	
Main phone:	Alternate phone:	Email:	Last 4 of SSN (required):		
Date of birth:	<input type="checkbox"/> Male or <input type="checkbox"/> Female	Height (required): <input type="checkbox"/> cm or <input type="checkbox"/> inches	Weight (required): <input type="checkbox"/> lb or <input type="checkbox"/> kg		

CLINICAL INFORMATION

Primary ICD-10 code:	Is patient currently on therapy? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Previous tried/failed therapies:
Allergies:	Current medications:	

Please include face sheet, copy of insurance cards (front and back), H&P, clinicals, and any available lab results.

PRESCRIPTION AND ORDERS

Medication	Dosing	Quantity	Refills
<input type="checkbox"/> Entyvio	Induction: <input type="checkbox"/> 300mg IV at 0, 2 & 6 weeks <input type="checkbox"/> Other: _____	Maintenance: <input type="checkbox"/> 300mg IV every 8 weeks after induction <input type="checkbox"/> Other: _____	<input type="checkbox"/> 3 doses for induction <input type="checkbox"/> 8-week supply for maintenance <input type="checkbox"/> Other: _____ x1 year unless otherwise noted: <input type="checkbox"/> _____ week supply <input type="checkbox"/> Other: x _____
<input type="checkbox"/> Infliximab (Remicade, Inflectra, Renflexis, Avsola*)	Induction: <input type="checkbox"/> 5mg/kg IV at 0, 2 & 6 weeks <input type="checkbox"/> Other: _____	Maintenance: <input type="checkbox"/> _____mg/kg IV every 8 weeks after induction <input type="checkbox"/> Other: _____	<input type="checkbox"/> 3 dose for induction <input type="checkbox"/> 8-week supply for maintenance <input type="checkbox"/> Other: _____ x1 year unless otherwise noted: <input type="checkbox"/> _____ week supply <input type="checkbox"/> Other: x _____
<i>* Pharmacy will select infliximab product unless preferred brand is indicated. <input type="checkbox"/> Preferred brand: _____</i>			
<input type="checkbox"/> Simponi Aria	Induction: <input type="checkbox"/> Adults: 2mg/kg IV at weeks 0 & 4 <input type="checkbox"/> Other: _____	Maintenance: <input type="checkbox"/> Adults: 2mg/kg IV every 8 weeks after induction <input type="checkbox"/> Other: _____	<input type="checkbox"/> 2 doses for induction <input type="checkbox"/> 8-week supply for maintenance <input type="checkbox"/> Other: _____ x1 year unless otherwise noted: <input type="checkbox"/> _____ week supply <input type="checkbox"/> Other: x _____
<input type="checkbox"/> Stelara Crohn's disease / ulcerative colitis	Induction: <input type="checkbox"/> Adults ≤55kg: 260mg IV at week 0 <input type="checkbox"/> Adults >55kg-85kg: 390mg IV at week 0 <input type="checkbox"/> Adults >85kg: 520mg IV at week 0	Maintenance (adults): <input type="checkbox"/> 90mg SC every 8 weeks after induction <input type="checkbox"/> Other: _____	<input type="checkbox"/> One dose for induction <input type="checkbox"/> 8-week supply for maintenance <input type="checkbox"/> No refills <input type="checkbox"/> Other: x _____
<input type="checkbox"/> Stelara Plaque psoriasis and psoriatic arthritis	Induction: <input type="checkbox"/> Adults ≤100kg: 45mg SC at weeks 0 & 4 <input type="checkbox"/> Adults >100kg: 90mg SC at weeks 0 & 4 <input type="checkbox"/> Other: _____	Maintenance: <input type="checkbox"/> Adults ≤100kg: 45mg SC every 12 weeks <input type="checkbox"/> Adults >100kg: 90mg SC every 12 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> One dose for induction <input type="checkbox"/> 12-week supply for maintenance <input type="checkbox"/> No refills <input type="checkbox"/> Other: x _____

Orders:

Clinical Pharmacist to dose and send orders for review/signature. **Labs:** _____

Flush Orders: Flush with sodium chloride 0.9% 5-10mL and Heparin 100 Units/mL 3-5mL if needed for catheter maintenance.

Supplies: Dispense ancillary supplies, including ambulatory infusion pump, as needed to provide home infusion therapy.

Pre-Treatment: Dispense one dose for each infusion:

- Acetaminophen 500mg PO: 500-1000mg, 15-30 min prior to infusion
- Diphenhydramine 25mg PO: 500-1000mg, 15-30 min prior to infusion
- Hydration: Sodium chloride 0.9% 100-500 mL IV over 30 min before each infusion, as needed

Adverse/Anaphylactic Reactions, per protocol:

- Epinephrine 1:1000, 1 mL x 2
- Diphenhydramine 25mg tab #2
- Sodium chloride 0.9% 1000 mL Bag #1
- Diphenhydramine 50mg/1mL vial #1

Nursing Orders for Home Infusion: MONITOR (IV only)
Observe: Vital signs prior to infusion. Blood pressure and pulse every 15 minutes for first hour, then every 30 minutes until stable infusion rate, then every hour. Watch for: Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.

PRN: Ondansetron 4mg slow IVP as pre-med for infusion induced nausea Other:

Toradol 15mg-30mg SIVP as pre-med for infusion induced headache or muscle pain

Methylprednisolone 1 mg/kg (12.5-125 mg) slow IVP as pre-med or PRN for infusion-related cutaneous reaction or headache

Ondansetron 4-8mg PO as pre-med, then every _____ hours x _____ post-infusion

PRESCRIPTION AND ORDERS

Physician name:	Practice site name:
Address:	City: State: Zip:
NPI:	Phone: Fax:

Office contact and special instructions:

Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's signature: _____ **Date:** _____

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