Birmingham ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

ENTYVIO (Vedolizumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

_____ Ulcerative Colitis _____ Crohn's Disease _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

ENTYVIO ORDERS/DOSAGE:

____ 300mg IV

FREQUENCY: ____ Dose at 2 weeks, then 6 and then every 8 weeks ____ Dose Every ____weeks ____ _____ (other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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INFLECTRA (Infliximab-Dyyb) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

____ Rheumatoid Arthritis _____ Psoriatic Arthritis _____Plaque Psoriasis

____ Ankylosing Spondylitis _____ Crohn's Disease _____Ulcerative Colitis ___ _____

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

INFLECTRA ORDERS/DOSAGE:

_____ mg/kg weight based / flat-dosed **(Circle one)** _____ (other)

FREQUENCY: _____ Every 2, 6 and then 8 weeks _____ Every _____ weeks

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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INJECTAFER (Ferric Carboxymaltose) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes and labs (CBC & Ferritin).

DIAGNOSIS (Please provide ICD-10 code):

_____ Iron Deficiency Anemia _____ _____ (Other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ 750mg IV in 2 doses separated by at least 7 days _____ _____ (Other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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STELARA IV (Ustekinumab) Order

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

_____ Crohn's Disease _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

STELARA IV ORDERS/DOSAGE: ____ Up to 55kg-260mg (2 vials)

____Greater than 55kg to 85kg-390mg (3 vials) ____ Greater than 85kg-520mg (4 vials)

____ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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STELARA SQ (Ustekinumab) Order

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

_____ Crohn's Disease _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

STELARA SQ ORDERS/DOSAGE: ____ 90mg Q 8 weeks

____ _____ (other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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CIMZIA (Certolizumab Pegol) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

____ Rheumatoid Arthritis ____ Psoriatic Arthritis ____ _____ (other)

____ Crohn's Disease ____ Ankylosing Spondylitis

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

CIMZIA ORDERS/DOSAGE: _____ 400mg SQ initially and at weeks 2 & 4 (induction)

_____ 200mg SQ every 2 weeks _____ 400mg SQ every 4 weeks (maintenance)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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ZINPLAVA (Bezlotoxumab) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes and labs (C. diff test).

DIAGNOSIS (Please provide ICD-10 code):

_____ Clostridium Difficile _____ _____ (Other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ 10mg/kg IV over 60 minutes as a single dose.

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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Infusion Order for Medication (Print) _____

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs.

DIAGNOSIS (Please provide ICD-10 code): _____

____ _____

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

____ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____