Gastroenterology Therapies

Referring Physician Orders Rev. 03.2025

Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Crohn's Disease (K50.00-K50.919), ICD10 _____ ☐ Other: _____, ICD10 _____

☐ Ulcerative Colitis (K51.00-K51.919), ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Cimzia® (certolizumab pegol)	400mg	☐ **INITIAL:** Inject 400mg SUBQ at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ **MAINTENANCE:** Inject 400mg SUBQ every 4 weeks x 1 year
Entyvio® (vedolizumab)	300mg	☐ **INITIAL:** Infuse IV over 30 minutes at Weeks 0, 2, 6, then every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 30 minutes every 8 weeks x 1 year
Infliximab and biosimilars: ☐ Avsola® ☐ Remicade® ☐ Inflectra® ☐ Renflexis®	☐ _____ **mg (5 mg/kg)** ☐ _____ **mg (10 mg/kg)** ☐ _____ **mg (** ____ **mg/kg)**	☐ **INITIAL:** Infuse IV over 2 hours at Weeks 0, 2, 6, then every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 2 hours every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 2 hours every _____ weeks x 1 year
Omvoh™ (mirikizumab)	☐ 900mg (for CD) ☐ 300mg (for UC)	☐ CD: Infuse 900mg IV over 90 minutes every 4 weeks x 3 doses ☐ UC: Infuse 300mg IV over 30 minutes every 4 weeks x 3 doses
Skyrizi® (risankizumab)	☐ 600mg (for CD) ☐ 1200mg (for UC)	☐ CD: Infuse 600mg IV over 1 hour every 4 weeks x 3 doses ☐ UC: Infuse 1200mg IV over 2 hours every 4 weeks x 3 doses
Stelara® (ustekinumab)	**INITIAL IV Dose:** ☐ <55kg – 260mg ☐ 55kg to 85kg – 390mg ☐ >85kg – 520mg	☐ Infuse IV over 1 hour x 1 dose
Tremfya® (guselkumab)	200mg	☐ Infuse IV over 1 hour every 4 weeks x 3 doses
Tysabri® (natalizumab) ☐ Patient enrolled in TOUCH Prescribing Program	300mg	☐ Infuse IV over 1 hour every 4 weeks x _____ months *Observe patient for 1 hour after completion of infusion.* ☐ If no hypersensitivity reaction observed with first 12 infusions, then post-infusion observations as directed by MD.

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Test Results (required)

- TB Screening for Cimzia, Entyvio, infliximab biosimilars, Omvoh, Skyrizi, Stelara and Tremfya (submit results from within 12 months to start and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening for Cimzia and infliximab biosimilars (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by: ☐ Infusion Center ☐ Referring Physician

Prior Failed Therapies (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____