



# GASTROINTESTINAL THERAPIES ORDER FORM

YOUR OSO REPRESENTATIVE:

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Is patient pregnant?  Yes  No Patient's Height: \_\_\_\_\_ Patient's Weight (kg): \_\_\_\_\_  
TB Test preformed?  Yes  No Date of Negative TB Test: \_\_\_\_\_

## DIAGNOSIS INFORMATION:

Ulcerative Colitis  Diagnosis Code: \_\_\_\_\_ Other: \_\_\_\_\_  
 Crohn's Disease  Diagnosis Code: \_\_\_\_\_

## PRE-MEDICATION

Tylenol (Acetaminophen) 650 mg PO  Benadryl 25 mg PO  Zyrtec 10 mg PO  
 Benadryl 25 mg slow IVP  Solu-medrol slow IVP  20 mg  40mg  100mg  Other: \_\_\_\_\_  
 Other: \_\_\_\_\_

## REMICADE (INFLIXIMAB)

Remicade \_\_\_\_\_ mg/kg IV at weeks 0,2,6 and then every 8 weeks x 1 year.  
 Remicade \_\_\_\_\_ mg/kg, continue IV every 8 weeks x 1 year. Last Infusion Date: \_\_\_\_\_  
 Remicade \_\_\_\_\_ mg/kg, continue IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

## BIOSIMILAR ORDER: INFLECTRA (INFLIXIMAB-dyyb) IF AVAILABLE

Inflectra \_\_\_\_\_ mg/kg IV at weeks 0,2,6 and then every 8 weeks x 1 year.  
 Inflectra \_\_\_\_\_ mg/kg, continue IV every 8 weeks x 1 year. Last Infusion Date: \_\_\_\_\_  
 Inflectra \_\_\_\_\_ mg/kg, continue IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

## ENTYVIO (VEDOLIZUMAB)

Entyvio 300 mg IV at weeks 0,2,6 and then every 8 weeks x 1 year.  
 Entyvio 300 mg continue IV every 8 weeks x 1 year. Last Infusion Date: \_\_\_\_\_

## STELARA

Single IV induction over 1 hour.  
 260mg  390mg  520mg. SubQ maintenance 90mg q 8 weeks after induction dose for 6 doses during year one.

## HUMIRA

160mg on day 1 (can split over 2 days) then  80mg on day 15, then  40mg on day 29 then,  40mg q other week.

## INJECTAFER

weight less than 50kg  dose is 15mg/kg.  
 weight 50kg or greater  dose is 1500mg split in 2 doses over at least 7 days by IVP or infusion.

## IN CASE OF REACTION

SOLU-MEDROL 2 mg/kg IV  
Follow Oso Protocol for anaphylaxis and infusion reactions

## LAB ORDER

SN to perform labs with each infusion: CBC, CMP, CRP  
 Vedolizumab Quant. w/ Antibodies  
 Infliximab Quant. w/ reflex to Antibodies

## NURSING

Oso to coordinate nursing services in Ambulatory Infusion Suite.

## PHYSICIAN INFORMATION

MD Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_