ameripharma™ SPECIALTY CARE

GASTROENTEROLOGY ORDER SET

P: (877) 778-0318 F: (877) 778-0399

Patient Information

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ❑ New to Therapy ❑ Continuing Therapy **Next Treatment Date:** _____

Patient Weight: _____ lbs. (required) Allergies: _____

Diagnosis	Medication Orders	Refills
❑ Crohn's Disease ❑ Ulcerative Colitis ❑ Other: _____ **ICD-10 Code:** _____	❑ **Cimzia** 400mg SubQ at weeks 0, 2, 4 and then every 4 weeks ❑ **Cimzia** _____ mg SubQ every _____ weeks ❑ **Infliximab or infliximab biosimilar** as required by patient's insurance ❑ Do not substitute. Infuse the following infliximab product: _____ *For AmeriPharma use only.* Brand: _____ Dose: _____ mg/kg Frequency: ❑ Every _____ weeks ❑ 0, 2, 6 then every 8 weeks ❑ **Skyrizi** initial infusion: 600mg IV at week 0, 4, and 8 ❑ **Skyrizi** maintenance: 360 mg SubQ at week 12, and every 8 weeks thereafter (to be evaluated by AmeriPharma) ❑ **Stelara** initial infusion: ❑ <55kg - 260 mg IV x 1 dose ❑ 55kg to 85kg - 390mg IV x 1 dose ❑ >85kg - 520mg IV x 1 dose ❑ **Stelara** maintenance: ❑ 90 mg SQ 8 weeks after initial infusion and then every 8 weeks ❑ **Tysabri** 300mg IV every 4 weeks ❑ **Entyvio** 300mg IV at 0, 2, 6 weeks and then Q8 weeks ❑ **Entyvio** 300mg IV every 8 weeks	❑ _____ ❑ x1 year

Premedication orders: Tylenol ❑ 1000mg ❑ 500mg PO, please choose one antihistamine:
❑ Diphenhydramine 25mg PO ❑ Loratadine 10mg PO ❑ Cetirizine 10mg PO ❑ Cetirizine 10mg IVP
Additional premedications: ❑ Solu-Medrol _____ mg IVP ❑ Solu-Cortef _____ mg IVP ❑ Other: _____
Lab orders: _____ Frequency: ❑ Every infusion ❑ Other: _____
❑ Yearly TB QFT ❑ Baseline HepBcAB total Required labs to be drawn by: ❑ AmeriPharma ❑ Referring Provider

Home biologic IV Ana-kit (adult): Dispense EpiPen 0.3mg IM (2-pack) or compounded syringe, diphenhydramine 50mg IV and PO, NS 10000mL per protocol
Home biologic injection Ana-kit (adult): Dispense EpiPen 0.3mg IM (2-pack) per protocol

Provider Information

Provider Name: _____ Provider's Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

❑ Opt out of AmeriPharma selecting site of care (if checked, please list site of care): _____ _____ _____
City State

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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COMPREHENSIVE SUPPORT FOR GASTROENTEROLOGY THERAPY

Patient Information

Patient Name: _____ DOB: _____

Required Documentation for Referral Processing & Insurance Approval

- ❑ Include signed and completed order (MD/prescriber to complete page 1)
- ❑ Include patient demographic information and insurance information
- ❑ Include patient's medication list
- ❑ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ❑ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., 6MP, Azathioprine)? ❑ Yes ❑ No
    If yes, which drug(s)? _____
  - ❑ For biologic orders, does the patient have a documented contraindication/intolerance or failed trial to any other biologic (i.e., Humira, Stelara, Cimzia)? ❑ Yes ❑ No
    If yes, which drug(s)? _____
- ❑ Include labs and/or test results to support diagnosis
- ❑ *If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting ordered biologic therapy.
- ❑ Other medical necessity: _____

Required Pre-Screening (Based on drug therapy)

- ❑ **TB Screening test completed within 12 months - attach results**
  Required for: Cimzia, Infliximab, Stelara, Entyvio, Skyrizi
  ❑ **Positive** ❑ **Negative**
- ❑ **Hepatitis B screening test completed (Hepatitis B surface antigen) - attach results**
  Required for: Cimzia, Infliximab
  ❑ **Positive** ❑ **Negative**
- ❑ **JCV antibody & TOUCH authorization**
  Required for: Tysabri
  ❑ **Positive** ❑ **Negative**
- ❑ **Labs indicating iron deficiency**
  Required for: Venofer, Injectafer, Monoferric
  *If TB or Hepatits B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

AmeriPharma Specialty Care will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer them to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (877) 778-0399 or call (877) 778-0318 for assistance.

Revised 2/26/2024