ameripharma® SPECIALTY CARE

GASTROENTEROLOGY REFERRAL FORM

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) Patient Height: _____ inches Allergies: _____

Diagnosis	ICD-10
❑ Crohn's Disease	K50
❑ Ulcerative Colitis	K51

Prescription	Directions, Quantity, Form	Refill
Tremfya	**Induction:** • ***IV:*** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ Tremfya 200mg/20mL Vial: 200mg IV on weeks 0, 4, and 8. Qty: 3 Sodium Chloride 0.9% 250mL Bag - UAD for Tremfya infusion. Qty: 3 • ***SubQ:*** ❑ Tremfya 200mg/2mL Pen: 400mg SubQ on weeks 0, 4, and 8. Qty: 6 **Maintenance:** • ***SubQ:*** ❑ Tremfya 100mg/mL One Press or Pen (as covered by insurance): 100mg SubQ every 8 weeks (beginning at week 16). Qty: 1	❑ x1 year ❑ Other: _____
Humira (or Humira biosimilar as covered by insurance)	**Induction:** ❑ Humira 80mg/0.8mL Pen Citrate Free: 160mg SubQ on day 1, then inject 80mg SubQ 2 weeks later (day 15). Qty: 3 **Maintenance:** ❑ Humira 40mg/0.4mL Pen Citrate Free: 40mg SubQ every other week (starting on day 29). Qty: 1	❑ x1 year ❑ Other: _____
Skyrizi (for Crohn's disease)	**Induction:** • ***IV:*** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ Skyrizi 600mg/10mL Vial: 600mg IV on weeks 0, 4, and 8. Qty: 3 ❑ Sodium Chloride 0.9% 250mL Bag - UAD for Skyrizi infusion. Qty: 3 **Maintenance:** • ***SubQ:*** (select one of the following doses) ❑ Skyrizi 180mg/1.2mL Cartridge: 180mg SubQ at week 12, then 8 weeks thereafter. Qty: 1 ❑ Skyrizi 360mg/2.4mL Cartridge: 360mg SubQ at week 12, then 8 weeks thereafter. Qty: 1	❑ x1 year ❑ Other: _____
Skyrizi (for Ulcerative colitis)	**Induction:** • ***IV:*** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ Skyrizi 600mg/10mL Vial: 1200mg IV on weeks 0, 4, and 8. Qty: 6 ❑ Sodium Chloride 0.9% 250mL Bag - UAD for Skyrizi infusion. Qty: 3 **Maintenance:** • ***SubQ:*** (select one of the following doses) ❑ Skyrizi 180mg/1.2mL Cartridge: 180mg SubQ at week 12, then 8 weeks thereafter. Qty: 1 ❑ Skyrizi 360mg/2.4mL Cartridge: 360mg SubQ at week 12, then 8 weeks thereafter. Qty: 1	❑ x1 year ❑ Other: _____
Stelara	**Induction:** • ***IV:*** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ ≤55kg: Stelara 130mg/26mL Vial: 260mg IV as a single dose. Qty: 2 Sodium Chloride 0.9% 250mL Bag - UAD for Stelara infusion. Qty: 1 ❑ 55kg to 85kg: Stelara 130mg/26mL Vial: 390mg IV as a single dose. Qty: 3 Sodium Chloride 0.9% 250mL Bag - UAD for Stelara infusion. Qty: 1 ❑ >85kg: Stelara 130mg/26mL Vial: 520mg IV as a single dose. Qty: 4 Sodium Chloride 0.9% 250mL Bag - UAD for Stelara infusion. Qty: 1 **Maintenance:** • ***SubQ:*** ❑ Stelara 90mg/mL PFS: 90mg SubQ after every 8 weeks from initial infusion, then 8 weeks thereafter. Qty: 1	❑ x1 year ❑ Other: _____

Prescription	Directions, Quantity, Form	Refill
Entyvio	**OPTION 1:** IV Only **Induction:** • ***IV:*** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ Entyvio 300mg Vial: 300mg IV at weeks 0, 2, and 6. Qty: 3 Sodium Chloride 0.9% 250mL Bag - Use as directed for Entyvio infusion. Qty: 3 Sodium Chloride 0.9% 50mL Bag - Flush IV line with 30mL after Entyvio infusion. Qty: 3 Sterile Water for Injection 10mL Vial - Use as directed to reconstitute Entyvio. Qty: 3 **Maintenance:** ❑ Entyvio 300mg Vial: 300mg IV every 8 weeks. Qty: 1 Sodium Chloride 0.9% 250mL Bag - UAD for Entyvio infusion. Qty: 1 Sodium Chloride 0.9% 50mL Bag - Flush IV line with 30mL after Entyvio infusion. Qty: 1 Sterile Water for Injection 10mL Vial - UAD to reconstitute Entyvio. Qty: 1 **OPTION 2:** IV to SubQ **Induction:** • ***IV:*** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ Entyvio 300mg Vial: 300mg IV at weeks 0 and 2. Qty: 2 Sodium Chloride 0.9% 250mL Bag - UAD for Entyvio infusion. Qty: 2 Sodium Chloride 0.9% 50mL Bag - Flush IV line with 30mL after Entyvio infusion. Qty: 2 Sterile Water for Injection 10mL Vial - UAD to reconstitute Entyvio. Qty: 2 **Maintenance:** ❑ Entyvio 108mg/0.68mL Pen: 108mg SubQ at week 6, then once every 2 weeks thereafter (beginning after at least 2 IV infusions). Qty: 2	❑ x1 year ❑ Other: _____
Infliximab (or Infliximab biosimilar as covered by insurance)	**Induction:** • ***IV:*** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ Infliximab 100mg Vial (or Infliximab biosimilar) - Infuse _____mg (dose 5mg/kg) intravenously on weeks 0, 2, and 6. Qty: QS Sterile Water for Injection 10mL Vial - UAD to reconstitute Infliximab. Qty: QS Sodium Chloride 0.9% 250mL OR 500mL Bag- UAD for Infliximab infusion. Qty: 1/dose *For doses < 999 mg= 250mL bag. For doses > 1000 mg= 500 mL bag* **Premedications (15-30 minutes prior to infusion):** • Acetaminophen 325mg Tablet - 2 tablets by mouth. Qty: 2/dose • Diphenhydramine HCL 25mg Capsule - 1-2 capsules by mouth. Qty: 2/dose ***OR*** ❑ Loratadine 10mg Tablet - 1 tablet by mouth. Qty: 1/dose *(Diphenhydramine PO will not be dispensed if selected)* ❑ Certirizine 10mg Tablet - 1 tablet by mouth. Qty: 1/dose *(Diphenhydramine PO will not be dispensed if selected)* **Maintenance:** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ Infliximab 100mg Vial (or Infliximab biosimilar) - Infuse _____mg (dose 5mg/kg) intravenously every 8 weeks (starting at week 14). Qty: QS Sterile Water for Injection 10mL Vial - UAD to reconstitute Infliximab. Qty: QS Sodium Chloride 0.9% 250mL OR 500mL Bag- UAD for Infliximab infusion. Qty: 1/dose *For doses < 999 mg= 250mL bag. For doses > 1000 mg= 500 mL bag* **Premedications (15-30 minutes prior to infusion):** • Acetaminophen 325mg Tablet - 2 tablets by mouth. Qty: 2/dose • Diphenhydramine HCL 25mg Capsule - 1-2 capsules by mouth. Qty: 2/dose ***OR*** ❑ Loratadine 10mg Tablet - 1 tablet by mouth. Qty: 1/dose *(Diphenhydramine PO will not be dispensed if selected)* ❑ Certirizine 10mg Tablet - 1 tablet by mouth. Qty: 1/dose *(Diphenhydramine PO will not be dispensed if selected)*	❑ x1 year ❑ Other: _____
Tysabri	**REQUIRED: Tysabri TOUCH Patient Enrollment #:** _____ • ***IV:*** ***Anaphylaxis kit and epinephrine pen to be dispensed*** ❑ Tysabri DS 300mg/15mL Vial: 300mg IV every 4 weeks. Qty: 1 Sodium Chloride 0.9% 100mL Bag - UAD for Tysabri infusion. Qty: 1	❑ x1 year ❑ Other: _____
Cimzia	**Induction:** ❑ Cimzia PFS Start Kit 6 X 200mg/mL: 400mg SubQ on week 0, 2, and 4. Qty: 3 **Maintenance:** ❑ Cimzia PFS 2 x 200mg/mL Kit: 400mg SubQ every 4 weeks. Qty: 1	❑ x1 year ❑ Other: _____

Additional Pre-Medication (15-30 minutes prior to infusion):

Solu-Medrol #1 vial/infusion + bacteriostatic water #1 vial: ❑ 40mg IVP ❑ 125mg IVP

Solu-Cortef #1 vial/infusion + bacteriostatic water #1 vial: ❑ 40mg IVP ❑100mg IVP

❑ Other _____

Flushing Protocol (for IV Infusions only) (Dispense quantity sufficient per protocol)	❑ Sodium Chloride 0.9% 5-10mL per SASH protocol • #3 per infusion day • +1 per additional IV infusion	❑ Heparin 3-5mL per SASH protocol If Port/PICC (500u/mL) #1 per infusion day

Anaphylactic Reaction Orders (for infusions only: Entyvio IV, Tremfya IV, Skyrizi IV, Stelara IV, Tysabri IV, Infliximab IV)

❑ Epinephrine (dosed by patient weight) #2 pens

- >30kg (>66lbs): EpiPen 0.3mg use as directed for anaphylaxis; may repeat in 5-10 minutes x1
- 15-30kg (33-66lbs): EpiPen 0.15mg use as directed for anaphylaxis; may repeat in 5-10 minutes x1

❑ **Anaphylaxis Kit:** Use in the event of an anaphylactic reaction per protocol.

- #2 Diphenhydramine HCL Injection 50mg/mL Vial (IV route) for a moderate reaction
- #2 Diphenhydramine HCL 25mg Capsules for a mild reaction
- #10 Sodium Cl 0.9% Flush Syr 10mL
- #2 Heparin Flush 500unit/5mL Syr (Only for PICC or Port patients)

Provider Information

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

Address, City, State, Zip: _____

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

Please kindly sign above to grant authorization for Harper's Pharmacy, Inc. operating as AmeriPharma, to undertake all necessary and reasonable actions, including submitting any necessary Prior Authorization requests on our behalf, to ensure the prompt and accurate dispensing of the medication(s) prescribed for the patient mentioned above. Pharmacy to dispense stock vials and IV supplies for administration. Prescriber or Nurse to reconstitute and/or dilute prior to infusion.

*For AmeriPharma Use Only

Notes: _____

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**

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.

Nursing Orders:

Assessment and Infusion Administration:

- RN to complete patient assessment prior to infusion.
- Administer via ambulatory rateflow regulator administration set.
- Notify the pharmacy immediately of any pump or supply issues.
- Pharmacy to provide all required infusion supplies, including: Catheter Care Kit [A4221] , Supply Kit [A222] , and ancillary medications/equipment [E0779 or E0781]

Vascular Access:

- RN to insert, maintain, and remove peripheral IV catheter (PIVC) or access central venous catheter using aseptic technique.
- Rotate PIVC as clinically indicated for signs of infiltration or irritation.
- Monitor patients throughout infusion. Discontinue PIVC upon completion of the infusion or infusion cycle.

Catheter Maintenance:

- Flush PIVC with 3-5 mL of 0.9% Sodium Chloride before and after each dose, with lab draws, and as needed to assess catheter patency.
- Flush Central Line (PICC,Hickman, etc) with 10mL of 0.9%Sodium Chloride before and after infusion.
- Lock Central Line (PICC, Hickman, etc) with 100units/mL, 5ml to maintain patency on treatment days, daily and PRN.
- For port access, use sterile technique with a non-coring needle. Flush with 10 mL of 0.9% Sodium Chloride before and after infusion.
- Lock port with Heparin 100 units/mL, 5 mL to maintain patency. Flush port on treatment days, at least once monthly, and PRN.
- De-access port post-infusion and apply sterile pressure gauze and transparent dressing.
- Discontinue port maintenance upon discontinuation of pharmacy services.
- RN to prepare and administer ordered medication, infusing full contents of infusion bag/vials per prescribed dose.
- Infusions may be administered within a +/- 3-day window to accommodate patient scheduling.

Patient and Caregiver Education:

- RN to provide education on: Monitoring for signs/symptoms of complications, Infection prevention and IV access safety, Emergency preparedness, 24-hour on-call availability, Safe medication handling and administration.

Coordination of Care:

- Pharmacy and nursing services may be discontinued if continuation orders are not received.
- Signed discharge orders must be on file prior to termination of services.

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