

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 500-3727 **F** (832) 500-8629 **E** specialty@hqrx.com

DATE: _____ NEXT TREATMENT DATE: _____

Please fax completed form along with copy of patient's insurance cards and any labs to **(832) 500-8629**

Patient Name _____	Prescriber's Name _____
Patient Address _____	DEA # _____ NPI # _____
City _____ State _____ Zip _____	Practice Name _____
Day Phone _____ Work Phone # _____	Office Contact _____
Cell Phone _____	Address _____ Suite # _____
Date of Birth _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	City _____ State _____ Zip _____
E-mail _____	Phone _____ Fax _____

DIAGNOSIS

Patient: Wt. _____ Ht. _____ Allergies: Latex Other, specify _____

ICD-10 DIAGNOSIS CODE K50.00 Crohn's Disease K51.90 Ulcerative Colitis Other: _____

Previously treated for this condition? Yes No Medication(s) failed: _____

Patient currently on therapy? Yes No Types/Medications: _____

Current medication, including OTC: _____ **PPD (TB Test):** Yes No Date: _____

PRESCRIPTION

DIAGNOSIS	INFUSION ORDERS	REFILLS
<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis Anaphylactic Reaction Orders: <ul style="list-style-type: none"> Epinephrine (based on patient weight) <ul style="list-style-type: none"> >30kg (>66lbs): Epinephrine 0.3mg IM or subQ; may repeat in 5-10 minutes x1 15-30kg (33-66lbs): Epinephrine 0.15mg IM or subQ; may repeat in 5-10 minutes x1 Diphenhydramine: Administer 25-50mg IV (adult) NS 0.9% 500mL IV bolus as needed (adult) Refer to physician order or institutional protocol for pediatric dosing and infusion reaction management Flush orders: NS 1-10mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN	<input type="checkbox"/> Cimzia ® 400 mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks <input type="checkbox"/> Cimzia ® _____ mg Sub-Q every _____ weeks <input type="checkbox"/> Entyvio ® 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8weeks (baseline LFTs) <input type="checkbox"/> Entyvio ® 300mg IV every 8 weeks <input type="checkbox"/> Infliximab ® _____ mg/kg Frequency: <input type="checkbox"/> Every ____ weeks OR <input type="checkbox"/> 0, 2, 6 then every 8 weeks <input type="checkbox"/> Omvo ™ induction dose: <input type="checkbox"/> 300mg or <input type="checkbox"/> 900mg IV at week 0, 4, and 8 <input type="checkbox"/> Omvo ™ maintenance dose: <input type="checkbox"/> 200mg or <input type="checkbox"/> 300mg SQ at week 12, then every 4 weeks thereafter <input type="checkbox"/> Skyrizi ® initial infusion: <input type="checkbox"/> 600mg or <input type="checkbox"/> 1,200mg IV at week 0, 4, and 8 weeks <input type="checkbox"/> Skyrizi ® maintenance: <input type="checkbox"/> 180mg SQ or <input type="checkbox"/> 360mg SQ at week 12, and every 8 thereafter (to be evaluated by HQRx) <input type="checkbox"/> Stelara ® initial infusion: <input type="checkbox"/> <55kg 260mg IV over 1 hour x 1 dose <input type="checkbox"/> 55kg to 85 kg 390mg IV over 1 hour x 1 dose <input type="checkbox"/> >85kg 520mg IV over 1 hour x 1 dose <input type="checkbox"/> Stelara ® maintenance: <input type="checkbox"/> 90mg SQ 8 weeks after initial then every 8 weeks <input type="checkbox"/> Tremfya ® loading dose: 200mg IV at week 0, 4, and 8 <input type="checkbox"/> Tremfya ® maintenance dose: <input type="checkbox"/> 100mg SQ at week 16, then every 8 weeks thereafter <input type="checkbox"/> 200mg SQ at week 12, then every 4 weeks thereafter <input type="checkbox"/> Tysabri ® 300 mg every 4 weeks <input type="checkbox"/> JCV antibody <input type="checkbox"/> Patient TOUCH authorization <input type="checkbox"/> Zymfentra ™ maintenance dose: 120mg SQ starting at week 10, then every 2 weeks thereafter <input type="checkbox"/> Other: _____ Premedication orders: Tylenol <input type="checkbox"/> 1000mg <input type="checkbox"/> 500mg PO <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Quzyttir 10mg IVP Additional premedications: <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Other: _____ Lab orders: _____ Required labs to be drawn by: <input type="checkbox"/> Infusion Center <input type="checkbox"/> Referring Provider	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year

Pharmacist may substitute brand based on product availability. If needed, dose to be rounded to nearest whole vial.

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.

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PATIENT INFORMATION

Patient Name _____ Date of Birth _____

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 contraindication to conventional therapy

Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? Yes No

If YES, which drug(s)? _____

Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira®, Enbrel®, Stelara®, Cimzia®)? Yes No

If YES, which drug(s)? _____

If psoriasis diagnosis, percent of body surface (BSA) involved: _____%

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 washout period of _____ weeks prior to starting Infliximab.

Other medical necessity: _____

REQUIRED PRE-SCREENING

TB screening test completed within 12 months - **attach results**

Positive Negative

Hepatitis B screening test completed.

This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) patient - **attach results**

Positive Negative

** If TB or Hepatitis B results are positive, please provide documentation of treatment or medical clearance, and a negative CXR (TB+)*

HealthQuest Infusion & Specialty 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 him/her to any available co-pay assistance as needed. Thank you for the referral.

Please **fax** all information to **(832) 500-8629**