

P:
| F:
PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

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

THERAPY ORDER

Diagnosis	Medication Orders	Refills
<input type="checkbox"/> Dehydration <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Gastroenteritis ICD-10 Code: _____	<input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters D5 .45 NS IV x 1 day <input type="checkbox"/> Other: _____ <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters NS IV x 1 day	
<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis **If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first or have a letter of medical necessity** ICD-10 Code: _____	<input type="checkbox"/> Venofer 200mg IV - Administer 5 doses over a 14 day period <input type="checkbox"/> Venofer 200mg IV weekly x 5 weeks <input type="checkbox"/> Injectafer 15mg/kg IV (<50kg) - Give 2 doses at least 7 days apart <input type="checkbox"/> Injectafer 750mg IV (≥50kg) - Give 2 doses at least 7 days apart <input type="checkbox"/> Monoferric 1000mg IV x1 dose (≥50kg) <input type="checkbox"/> Monoferric 20mg/kg IV x1 dose (<50kg)	
<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Other: _____ ICD-10 Code: _____	<input type="checkbox"/> Cimzia 400mg SubQ at weeks 0, 2, 4 and then every 4 weeks <input type="checkbox"/> Cimzia _____ mg SubQ every _____ weeks <input type="checkbox"/> Infliximab or infliximab biosimilar as required by patient's insurance <input type="checkbox"/> Do not substitute. Infuse the following infliximab product: _____ For Compassus use only. Brand: _____ Dose: _____ mg/kg Frequency: <input type="checkbox"/> Every _____ weeks OR <input type="checkbox"/> 0, 2, 6 then every 8 weeks <input type="checkbox"/> Skyrizi initial infusion: 600mg IV at week 0, 4, and 8 weeks <input type="checkbox"/> Skyrizi maintenance: 360mg SubQ at week 12, and every 8 weeks thereafter (to be evaluated by Compassus Pharmacy) <input type="checkbox"/> Stelara initial infusion: <input type="checkbox"/> <55kg - 260mg IV x 1 dose <input type="checkbox"/> 55kg to 85kg - 390mg IV x 1 dose <input type="checkbox"/> >85kg - 520 mg IV x 1 dose <input type="checkbox"/> Stelara maintenance: <input type="checkbox"/> 90mg SQ 8 weeks after initial infusion and then every 8 weeks <input type="checkbox"/> Tysabri 300mg IV every 4 weeks <input type="checkbox"/> Entyvio 300mg IV at 0, 2, 6 weeks and then Q8 weeks <input type="checkbox"/> Entyvio 300mg IV every 8 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year

Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:

☐ Diphenhydramine 25 mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg ☐ Quzyttir 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

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Compassus and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

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

PREFERRED LOCATION

City: _____ State: _____

Compassus

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GASTROENTEROLOGY ORDER SET

P:

| F:

PATIENT INFORMATION

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND 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 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 DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ **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, Monoferic

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

Compassus 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

or call

for assistance

Compassus

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