PUREONE INFUSION

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New Referral **Dose or Frequency Change** **Order Renewal**

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Allergies: _____ Weight:(lbs) _____ Height:_____

Phone: _____ Email: _____

ICD CODE/ICD DESCRIPTION

_____ _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider NPI: _____

Phone: _____ Fax: _____

Practice Site Name: _____

Practice Address: _____

REQUIRED DOCUMENTATION

- This order is signed by provider
- Patient's demographics AND insurance information
- Tried and failed therapies
- Clinical/progress notes supporting primary diagnosis
- Labs and tests supporting primary diagnosis
- Pregnancy test (if applicable)

HAS PATIENT RECEIVED TB TEST? IF YES, DATE: _____

MEDICATION ORDERS

	Remicade	**Inflectra**	**Avsola**
Loading dose:	5mg/kg	7.5mg/kg	10mg/kg at 0, 2, and 6 weeks then every ____ weeks thereafter

OR Flat rate dose _____ mg every _____ weeks

Entyvio
300 mg IV at 0, 2 and 6 weeks then every ____ weeks thereafter
OR every ____ weeks

Skyrizi
Crohn's loading doses: 400 mg IV at weeks 0, 4, and 8
Ulcerative Colitis and Crohn's loading doses: 200 mg IV at weeks 0, 4, and 8

Maintanence dosing: Inject 360 mg SC at week 12 and then every 8 weeks thereafter

Other: Include dosage, frequency and any other special instructions

_____

Refills: x6 months x1 year doses
***Order valid x1 year unless indicated**

Special Instructions

_____

_____ _____ ____ /____ /____
Provider Name Provider Signature Date