NuCara INFUSION SERVICES

6111 Burnet Rd.
Austin, TX 78757
Phone: 512.454.9923
Fax: 512.454.9866

ENTYVIO (VEDOLIZUMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis
- ☐ **Required Labs:** TB Test & Baseline Liver Enzymes

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

J Code: J3380

Diagnosis:

☐ Crohn's Disease (_____)

☐ Ulcerative Colitis (_____)

Labs:

Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

ENTYVIO ORDERS

Entyvio Dose: ☐ 300mg IV to be infused over 30 minutes

Frequency: ☐ 0,2,6 then Every 8 weeks or ☐ Every_____weeks

TB: ☐ TB Test Attached

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD.

Required Lab: Baseline Liver Enzymes (within 6 months, preferably)

****Date of last** ☐ Remicade ☐ Humira ☐ Stelara ☐ Other:_____ dose:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	

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INFLECTRA (INFLIXIMAB-DYYB)
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ TB & Hepatitis B documentation, CBC and Liver function should be followed at regular intervals

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Q code: Q5102

Diagnosis:

☐ Crohn's Disease (_____) ☐ Ulcerative Colitis (_____)
☐ Rheumatoid Arthritis (_____) ☐ Ankylosing Spondylitis (_____)
☐ Psoriasis (_____) ☐ Other_____ (_____)

Labs:

Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

INFLECTRA ORDERS

Inflectra Dose:_____mg/kg Pt. Weight _____ lbs.

Frequency: Every_____weeks or ☐ 0, 2, 6 then Every 8 weeks

P1 otocol Pre-Medication Orders: Tylenol l000mg PO, *please choose one antihistamine:*
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IV
☐ Solu-Cortef _____ mg IV

TB: ☐ TB Test Attached ☐ Perform TB Testing

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

****Date of last** ☐ Orencia ☐ Remicade ☐ Humira or ☐ Enbrel dose:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	

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CIMZIA (CERTOLIZUMAB PEGOL)
SUB-Q ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

J Code: J0717

Diagnosis:

☐ Crohn's Disease (ICD-10 Code:_____)
☐ Ankylosing Spondylitis (ICD-10 Code: _____)
☐ Psoriatic Arthritis (ICD-10 Code:_____)
☐ Other_____ (_____)
☐ Rheumatoid Arthritis (ICD-10 Code:_____)

Labs:

Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

CIMZIA ORDERS

Initial dose: ☐ 400mg Sub-Q at weeks 0, 2, and 4

Maintenance dose: ☐ 200mg Sub-Q every two weeks
☐ 400mg Sub-Q every four weeks

TB: ☐ TB Test Attached ☐ Perform TB Testing

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

****Date of last** ☐ Remicade ☐ Orencia ☐ Humira ☐ CIMZIA dose:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	

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STELARA (USTEKINUMAB)
MEDICATION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ TB documentation

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis: ☐ Plaque Psoriasis (ICD-10: _____) ☐ Psoriatic Arthritis (ICD-10: _____)

Pt. Weight _____ lbs.

Stelara: ☐ Patients weighing < 100kg (220 lbs), 45mg subQ initially and 4 weeks later, followed by 45mg every 12 weeks
☐ Patients weighing > 100kg (220 lbs), 90mg subQ initially and 4 weeks later, followed by 90mg every 12 weeks
☐ Other:_____

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*

Diagnosis: ☐ Crohn's (ICD-10: _____) Pt. Weight _____ lbs.

Stelara Initial Infusion: ☐ <55kg (121 lbs) 260mg IV over 1 hour x 1 dose
☐ 55kg to 85kg (121 lbs to 187 lbs) 390 mg IV over 1 hour x 1 dose

Stelara Maintenance: ☐ >85kg (187 lbs) 520 mg IV over 1 hour x 1 dose
☐ 90 mg SQ 8 weeks after initial infusion and then refill every 8 weeks for 1 year for a total of 6 refills

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	

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REMICADE (INFLIXIMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ TB & Hepatitis B documentation, CBC and Liver function should be followed at regular intervals

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

J Code: J1745

Diagnosis:

☐ Crohn's Disease (_____) ☐ Ulcerative Colitis (_____)
☐ Rheumatoid Arthritis (_____) ☐ Ankylosing Spondylitis (_____)
☐ Psoriasis (_____) ☐ Other_____ (_____)

Labs:

Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

REMICADE ORDERS

Remicade Dose: _____mg/kg Pt. Weight _____ lbs.

Frequency: Every_____weeks or ☐ 0, 2, 6 then Every 8 weeks

Protocol Pre-Medication Orders: Tylenol 1000mg PO, *please choose one antihistamine:*

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

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IV
☐ Solu-Cortef _____ mg IV

TB: ☐ TB Test Attached ☐ Perform TB Testing

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

****Date of last** ☐ Orencia ☐ Remicade ☐ Humira or ☐ Enbrel dose:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	