



Jupiter Infusion
 140 Jupiter Lakes Blvd, Suite A
 Jupiter, FL 33458
 Office: 561-277-9211

Gastroenterology order form

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Medication Orders	Refills
<input type="checkbox"/> Dehydration <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Gastroenteritis ICD-10: _____	<input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters D5 0.45 NS IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters NS IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters Lactated Ringer's IV x 1 day <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis ICD-10: _____ **If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first**	<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 20mg/kg IV x 1 dose (<50kg) <input type="checkbox"/> Monoferric 1000mg IV x 1 dose (>50kg)	
<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Other: _____ ICD-10: _____	<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 the patient's insurance Dose: _____ mg/kg Frequency: <input type="checkbox"/> Every _____ weeks OR <input type="checkbox"/> 0, 2, 6, then every 8 weeks <input type="checkbox"/> Do not substitute. Infuse the following infliximab product: _____ <input type="checkbox"/> Skyrizi initial infusion: 600mg IV at week 0, 4, and 8 weeks <input type="checkbox"/> Skyrizi maintenance: 360mg Sub-Q at week 12 and then every 8 weeks <input type="checkbox"/> Stelara initial infusion: <input type="checkbox"/> 260mg IV x 1 dose (<55kg) <input type="checkbox"/> 390mg IV x 1 dose (55-85kg) <input type="checkbox"/> 520mg IV x 1 dose (>85kg) <input type="checkbox"/> Stelara maintenance: 90mg SubQ 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 every 8 weeks <input type="checkbox"/> Entyvio 300mg IV every 8 weeks	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
Premedication orders: Tylenol <input type="checkbox"/> 1000mg OR <input type="checkbox"/> 500 mg PO Please choose one antihistamine: <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Other: _____ Additional premedications: <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Other: _____		

Please provide patient's demographic information, insurance information, medication list, and clinical notes. JUPITER INFUSION 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 assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____