PHONE# 678-379-1806
Fax# 470-531-8298

https://www.gicinfusion.com/

INFUSION ORDER FORM

Locations in Athens, Atlanta, Alpharetta, Lawrenceville, Marietta

Fax this completed form along with a copy of patient's insurance card, recent clinical notes supporting this ICD code, and labs.

Patient Name: _____ **DOB:** _____ **Phone:** _____

PATIENT STATUS: ☐ NEW TO THERAPY ☐ CONTINUATION OF THERAPY **LAST TREATMENT DATE:** _____

ICD-10 CODE: _____ **Patient weight:** _____ **lbs.** _____ **kg**

LABS (specify which ones and how often): _____

DRUG ALLERGIES: _____

PPD TEST / QUANT GOLD DATE: _____ **RESULTS:** ☐ **POS** ☐ **NEG** ☐ **DRAWN YEARLY**

☐ **Entyvio**	☐ 300 mg vial	☐ Initial Start: 300mg IV at 0,2,6, then every 8 weeks x1 year ☐ 300mg IV every 8 weeks x1 year ☐300mg IV every _____ weeks x1 year	
☐ **Infliximab**	****Please choose one:** **Dose: _____mg/kg** **OR** **Dose: _____ mg** ☐ Nurse will round to the nearest 100 mg. ☐ Give exact dose do not round.	☐ Infuse Infliximab **or** Infliximab biosimilar as required by the insurance plan. ****Preferred product to be determined after benefit verification**** ☐ Do not substitute biosimilars. Infuse the following Infliximab: _____ FREQUENCY: ☐ 0,2,6, THEN EVERY 8 WEEKS **(Initial Start)** x1 YEAR ☐ EVERY _____ WEEKS (**Maintenance dose**) x1 YEAR	
☐ **Stelara**	☐ 130 mg / 26 ml vial ☐ 90 mg injection (2x 45mg vials)	☐ < 55 kg: 260 mg IV over 1 hour x 1 dose ☐ 55 kg to 85 kg: 390 mg IV over 1 hour x 1 dose ☐ > 85 kg: 520 mg IV over 1 hour x 1 dose ☐ MAINTENANCE: inject 90 mg SQ 8 weeks after initial dose	
☐ **Skyrizi**	☐ 600 mg / 10 ml vial ☐ 1200 mg / 10 ml vial	☐ INITIAL: Infuse 600 mg /10 mL IV at week 0, 4, and 8 (Crohn's Diagnosis) ☐ INITIAL: Infuse 1200 mg /10 mL IV at week 0, 4, 8 (UC Diagnosis)	
☐ **Venofer**	☐ 200 mg IV	☐ Frequency_____	
Pre-medication & other medications:		☐ Acetaminophen _____ mg PO ☐ Diphenhydramine _____ mg PO ☐ Cetirizine _____ mg PO	☐ Solu-medrol _____ IVP ☐ Solu-cortef _____ IVP

PROVIDER INFORMATION **DATE:**

Provider Name**:** _____ SIGNATURE: _____

Provider NPI:_____ Phone:_____ Fax:_____

Our office will contact the patient to schedule infusion. For questions, contact our (Authorization Specialist) Susan Abraham at 678-379-1806. You can also contact our Infusion RN Managers, Cassie or Liz, at 470-785-4616. If this is an urgent request, please call our office prior to faxing information.

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