BEAUMONT INFUSION CENTERS
GASTROENTEROLOGY PRESCRIPTION

Location / ☐ **Royal Oak : 248- 551-3168** ☐ **Troy : 248-964-2409** ☐ **Lenox : 947-523-4061** ☐ **Wayne : 734-467-2505**
Fax Number ☐ **Grosse Pointe : 586-498-4497** ☐ **Farmington Hills : 248-471-8217** ☐ **Dearborn : 313-593-8551** ☐ **Livonia : 734-542-3356**

Patient Name:	**Date of Birth:**	**Medical Record #:**
Physician Name:	**Address:**	**Office #:**
Anticipated Start Date for Care:	**Diagnosis:**	**Diagnosis Code (ICD-10):**

PATIENT INFORMATION

Please attach these *required* documents to Prescription (if not in EPIC):

● Copy of Insurance Card ● Labs ● Supporting clinical documentation ● Patient Demographics

☐ NKDA
☐ Drug Allergies: _____

Height: _____ Weight: _____ kg/lbs Date: _____

REQUIRED LABS FOR THERAPY (To be Completed By Physician Office)
Remicade/Stelara: Current TB Test. Date of Test: _____ Result:_____

MEDICATION	**DOSE**	**# Doses**
INFLIXIMAB (REMICADE)	_____ mg/kg x _____ kg = _____ mg (rounded to the nearest 100 mg). ☐ Induction dosing at 0, 2, and 6 weeks. ☐ Maintenance Dosing every _____ weeks. ☐ Traditional Infusion Rate. Infuse over NO LESS THAN 2 HOURS. **TIME (min) / INFUSION RATE / TIME (min) / INFUSION RATE** 0 Initiate at 10 ml/hr — 60 Increase to 150 ml/hr 15 Increase to 20 ml/hr — 90 Increase to 250 ml/hr 30 Increase to 40 ml/hr — 120 End of Therapy 45 Increase to 80 ml/hr ☐ Rapid Infusion Rate: Infuse over 60 minutes. Per hospital guidelines, one hour infusions are permitted pursuant to a prescriber-order in pediatric and adult outpatients who have previously received at least 4 infliximab infusions without infusion reactions. **Pre Medications:** ☐ Acetaminophen ☐ 325mg, ☐ 500 mg, ☐ 650 mg, ☐ 1000 mg PO ½ hour prior to infusion. ☐ Diphenhydramine 25mg PO ½ hour prior to infusion. ☐ Hydrocortisone ____ mg IV one time only 30 minutes prior to infusion ☐ Methylprednisolone _____mg IV one time only 30 minutes prior to infusion	
VEDOLIZUMAB (ENTYVIO)	**Initial Dose:** ☐ 300 mg IV over 30 minutes at weeks 0, 2, and 6 **Maintenance Dose:** ☐ 300 mg IV over 30 minutes every 8 weeks **Pre-Meds:** ☐ Diphenhydramine 25 mg PO Q6h PRN minor itching, or rash	
USTEKINUMAB (STELARA)	**Dosage:** **Body weight of Patient — Dose** ☐ ≤55 kg — 260 mg ☐ 55.1-85 kg — 390 mg ☐ >85 kg — 520 mg ☐ Induction dosing IV x 1 dose. Infuse over 60 minutes.	

- 250 ml 0.9% Sodium Chloride flush bag with infusion as needed.
- Adult Anaphylaxis Protocol. Notify physician if reaction occurs.
- Flush IV with 10cc NS as needed.

Physician Signature _____ **Beeper #**_____ **Date** _____**Time**_____