

**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 : 313-593-5802  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: \_\_\_\_\_  
**Infliximab:** Hepatitis B screening completed and patient is clear to receive treatment  Yes  No

MEDICATION	DOSE	# Doses																				
<b>INFLIXIMAB (REMICADE)</b>	<p>_____ mg/kg x _____ kg = _____ mg (rounded to the nearest 100 mg).</p> <p><input type="checkbox"/> Induction dosing at 0, 2, and 6 weeks.</p> <p><input type="checkbox"/> Maintenance Dosing every _____ weeks.</p> <p><input type="checkbox"/> Traditional Infusion Rate. Infuse over NO LESS THAN 2 HOURS.</p> <table border="1" style="margin-left: 20px; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>TIME (min)</th> <th>INFUSION RATE</th> <th>TIME (min)</th> <th>INFUSION RATE</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>Initiate at 10 ml/hr</td> <td>60</td> <td>Increase to 150 ml/hr</td> </tr> <tr> <td>15</td> <td>Increase to 20 ml/hr</td> <td>90</td> <td>Increase to 250 ml/hr</td> </tr> <tr> <td>30</td> <td>Increase to 40 ml/hr</td> <td>120</td> <td>End of Therapy</td> </tr> <tr> <td>45</td> <td>Increase to 80 ml/hr</td> <td></td> <td></td> </tr> </tbody> </table> <p>*For subsequent infusions: If patient tolerates infusion, may infuse over 2 hours without titration.</p> <p><input type="checkbox"/> 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.</p> <p><b>Pre Medications:</b></p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 325mg, <input type="checkbox"/> 500 mg, <input type="checkbox"/> 650 mg, <input type="checkbox"/> 1000 mg PO ½ hour prior to infusion.</p> <p><input type="checkbox"/> Diphenhydramine 25mg PO ½ hour prior to infusion.</p> <p><input type="checkbox"/> Methylprednisolone _____ mg IV one time only 30 minutes prior to infusion</p>	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			
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<b>VEDOLIZUMAB (ENTYVIO)</b>	<p><b>Initial Dose:</b></p> <p><input type="checkbox"/> 300 mg IV over 30 minutes at weeks 0, 2, and 6</p> <p><b>Maintenance Dose:</b></p> <p><input type="checkbox"/> 300 mg IV over 30 minutes every 8 weeks</p> <p><b>Pre-Meds:</b></p> <p><input type="checkbox"/> Diphenhydramine 25 mg PO Q6h PRN minor itching, or rash</p>																					
<b>USTEKINUMAB (STELARA)</b>	<p><b>Dosage:</b></p> <table style="margin-left: 20px;"> <thead> <tr> <th style="text-align: left;">Body weight of Patient</th> <th style="text-align: left;">Dose</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> ≤55 kg</td> <td>260 mg</td> </tr> <tr> <td><input type="checkbox"/> 55.1-85 kg</td> <td>390 mg</td> </tr> <tr> <td><input type="checkbox"/> &gt;85 kg</td> <td>520 mg</td> </tr> </tbody> </table> <p><input type="checkbox"/> Induction dosing IV x 1 dose. Infuse over 60 minutes.</p>	Body weight of Patient	Dose	<input type="checkbox"/> ≤55 kg	260 mg	<input type="checkbox"/> 55.1-85 kg	390 mg	<input type="checkbox"/> >85 kg	520 mg													
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- 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 \_\_\_\_\_