Ascension at Home | TOGETHER WITH COMPASSUS®

GASTROENTEROLOGY ORDER SET
P: 800-648-8055 | F: 414-563-0600

PATIENT INFORMATION

Fax completed form, insurance information and clinical documentation to 414-563-0600

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ❒ New to Therapy ❒ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Patient weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Medication Orders	Refills
❒ Dehydration ❒ Diverticulitis ❒ Gastroenteritis **ICD-10 Code:** _____	❒ 1 Liter ❒ 2 Liters D5 .45 NS IV x 1 day ❒ Other: _____ ❒ 1 Liter ❒ 2 Liters NS IV x 1 day	
❒ Crohn's Disease ❒ Ulcerative Colitis ❒ Other: _____ **ICD-10 Code:** _____	❒ **Cimzia** 400mg SubQ at weeks 0, 2, 4 and then every 4 weeks ❒ **Cimzia** _____ mg SubQ every _____ weeks ❒ **Infliximab or infliximab biosimilar** as required by patient's insurance ❒ Do not substitute. Infuse the following infliximab product: _____ *For Ascension at Home Together with Compassus use only.* Brand: _____ Dose: _____ mg/kg Frequency: ❒ Every _____ weeks OR ❒ 0, 2, 6 then every 8 weeks ❒ **Skyrizi** initial infusion: 600mg IV at week 0, 4, and 8 weeks ❒ **Skyrizi** initial infusion: 1200 mg IV at week 0,4, and 8 weeks ❒ **Skyrizi** maintenance: 360mg SubQ at week 12, and every 8 weeks thereafter (to be evaluated by Compassus Pharmacy) ❒ **Stelara** initial infusion: ❒ <55kg - 260mg IV x 1 dose ❒ 55kg to 85kg - 390mg IV x 1 dose ❒ >85kg - 520 mg IV x 1 dose ❒ **Stelara** maintenance: ❒ 90mg SQ 8 weeks after initial infusion and then every 8 weeks ❒ **Tremfya** 200 mg IV (250 mL NS) over an hour at 0, 4 and 8 weeks ❒ **Tremfya** maintenance: _____ mg subcutaneous every 8 weeks ❒ **Tysabri** 300mg IV every 4 weeks ❒ **Entyvio** 300mg IV at 0, 2, 6 weeks and then Q8 weeks ❒ **Entyvio** 300mg IV every 8 weeks	❒ _____ ❒ x 1 year

Premedication orders: Tylenol ❒ 1000mg ❒ 500mg PO, please choose one antihistamine:
❒ Diphenhydramine 25 mg PO ❒ Loratadine 10mg PO ❒ Quzyttir 10mg IVP

Additional premedications: ❒ Solu-Medrol _____ mg IVP ❒ Cetrizine _____ mg IVP
❒ Other: _____

Lab orders: _____ **Frequency:** ❒ Every infusion ❒ Other: _____
❒ Yearly TB QFT ❒ Baseline HepBcAB total

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Ascension at Home together with Compassus and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

❒ Opt out of AAH together with Compassus selecting Site of care (if checked, please list site of care) _____

PREFERRED LOCATION

City: _____ State: _____

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REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

❒ Include signed and completed order (MD/prescriber to complete page 1)

❒ Include patient demographic information and insurance information

❒ Include patient's medication list

❒ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

❒ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., 6MP, azathioprine)? ❒ Yes ❒ No
If yes, which drug(s)? _____

❒ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Humira, Stelara, Cimzia)? ❒ Yes ❒ No
If yes, which drug(s)? _____

❒ Include labs and/or test results to support diagnosis

❒ If applicable - Last known biological therapy: _____ and last date received: _____.
If patient is switching to biologic therapies, please perform a wash out period of _____ weeks prior to starting ordered biologic therapy.

❒ Other medical necessity: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

❒ **TB screening test completed within 12 months - attach results**
Required for: Cimzia, Infliximab, Stelara, Entyvio, Skyrizi
❒ **Positive** ❒ **Negative**

❒ **Hepatitis B screening test completed (Hepatitis B surface antigen) - attach results**
Required for: Cimzia, Infliximab
❒ **Positive** ❒ **Negative**

❒ **JCV antibody & TOUCH authorization**
Required for: Tysabri
❒ **Positive** ❒ **Negative**

❒ **Labs indicating iron deficiency** Required for: Venofer, Injectafer, Monoferric

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Ascension at Home together with Compassus 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 refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to 414-563-0600 or call 800-648-8055 for assistance