BAPTIST | CANCER CENTER

GASTROINTESTINAL

Phone: (901) 752-6131
Fax: (901) 722-0570

Patient Demographics

_____ _____
Last Name First Name Middle Initial Social Security Number

_____ _____ _____ _____
Date of Birth Phone Number Insurance Provider ID Number

Provider Information

_____ _____ _____
Referring Provider Name Phone Number Practice Contact (Name)

Clinical Information

_____ _____ **Allergies:**_____
Diagnosis ICD-10 code

Prescriber's Orders: orders expire after 12 months

☐	INITIAL **Certolizumab pegol (CIMZIA**), 400mg, Subcutaneous, Every 2 weeks for 3 doses followed by 200mg every 2 weeks maintenance, for _____ treatments –OR– ☐ **Certolizumab pegol (CIMZIA),** 400mg, Subcutaneous, Every 2 weeks for 3 doses followed by 400mg every 4 weeks maintenance, for _____ treatments
☐	MAINTENANCE **Certolizumab pegol (CIMZIA**), 200mg, Subcutaneous, Every 2 weeks, for _____ treatments –OR– ☐ **Certolizumab pegol (CIMZIA),** 400mg, Subcutaneous, Every 4 weeks, for _____ treatments
☐	**Guselkumab (TREMFYA),** 200mg, Intravenously over 60 minutes, Every 4 weeks, for 3 treatments
☐	**Immune globulin** _____ g/kg (dosing is based on Ideal Body Weight), Intravenously beginning at 0.5 mg/kg/min and if no reactions, double every 30 minutes to a MAX rate of 8 mg/kg/min for the first infusion. Subsequent infusions may begin at 4 mg/kg/min and if no reactions, increase after 30 minutes to MAX of 8 mg/kg/min, Every ____ weeks, for _____ treatments Pre-medicate with PO diphenhydramine 25mg and PO acetaminophen 650mg, Once, prior to each infusion Note: orders for any IVIG product will automatically interchange to our preferred product
☐	**Infliximab** ____mg/kg, Intravenously over 90 minutes x 1 dose followed by subsequent infusions over 60 minutes, Every ____ weeks Pre-medicate with PO diphenhydramine 25mg and PO acetaminophen 650mg, Once, 30 minutes prior to each infusion Note: orders for infliximab will be automatically interchanged to the preferred biosimilar
☐	**Mirikizumab (OMVOH)** 300 mg, Intravenously over 30 minutes, Every 4 weeks, for 3 treatments (IV loading doses only)
☐	**Natalizumab (TYSABRI)** 300 mg, Intravenously over 60 minutes, Every 4 weeks, for _____ treatments
☐	**Risankizumab (SKYRIZI)** 600 mg, Intravenously over 60 minutes, Every 4 weeks for 3 treatments
☐	**Ustekinumab (STELARA),** _____ mg, Intravenously over 60 minutes, Once (IV loading dose only) Note: orders for ustekinumab will be automatically interchanged to the preferred biosimilar
☐	**Vedolizumab (ENTYVIO)** 300 mg, Intravenously over 30 minutes, Every ___ weeks, for _____ treatments

Additional Order Comments:	

_____ _____ _____
Physician Signature Printed name Date/time

BAPTIST | CANCER CENTER

GASTROINTESTINAL

Phone: (901) 752-6131
Fax: (901) 722-0570

In order to refer a patient to one of the Baptist Infusion Centers, please send the following information:

- ☐ Patient's complete demographics, including insurance information
- ☐ A copy of the patient's diagnosis with the appropriate ICD-10 diagnosis code, preferably in the provider's note
- ☐ A copy of the most recent labs and the most recent provider's progress note
- ☐ A copy of the Baptist Cancer Center order sheet with the correct drug selected and the order signed, dated, and timed

- **TB testing:** must be documented at initiation with referrals for certolizumab, infliximab, mirikizumab, risankizumab, tocilizumab, ustekinumab, and vedolizumab.
- **Hepatitis B testing:** must be documented at initiation with referrals for abatacept, certolizumab, infliximab, risankizumab, rituximab, and tocilizumab.
- **CMP:** send a CMP with new orders and every 12 months during treatment for immune globulin (IVIG), infliximab, and mirikizumab
- **Natalizumab (Tysabri):** send signed Patient-Prescriber enrollment form from the TOUCH REMS program at initiation

- We will not proceed with prior authorization or scheduling the patient for treatment until all information requested is provided
- Please ensure that we have a valid contact name and number should we need to call for additional information or to clarify orders
- Please note that orders are only valid for 12 months. After that time, new orders and new documentation must be provided.

Thank you for allowing Baptist Cancer Center to care for your patients.