



Patient Information	Prescriber Information
Name:	Prescriber Name:
DOB:	NPI:
Address:	Address:
City: State:	City:
Zip: Weight:	State: Zip:
Phone:	Phone:
Allergies:	Fax:

Diagnosis (please provide ICD-10 code in space provided):

Crohn's Disease Ulcerative Colitis Iron Deficiency Anemia Other

Nursing Orders: Hold infusion and notify provider for:

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles.

If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Drug	Dosing
Cimzia (certolizumab pegol)	☐ 400mg SubQ at weeks 0, 2, 4 and then every 4 weeks ☐ mg SubQ every weeks
Entyvio (vedolizumab)	☐ 300mg IV at 0, 2, 6 weeks and then every 8 weeks ☐ 300mg IV every 8 weeks ☐ 300mg IV at 0 and 2 weeks (IV to SubQ dosing)
Skyrizi (risankizumab)	Initial infusion: ☐ 600mg or ☐ 1200mg IV at weeks 0, 4, and 8 weeks Maintenance*: ☐ 180mg or ☐ 360mg SubQ at week 12, and every 8 weeks thereafter
☐ Stelara or ustekinumab biosimilar (as required by patient's insurance) ☐ Do not substitute. Infuse the following ustekinumab product: 	Initial infusion: ☐ 260mg ☐ 390mg ☐ 520mg IV x 1 dose Maintenance*: ☐ 90mg SQ 8 weeks after initial infusion and then every 8 weeks thereafter For Allied use only. Brand:
OmvoH (mirikizumab)	Initial infusion: ☐ 300mg or ☐ 900mg IV at 0, 4, and 8 weeks Maintenance*: ☐ 200mg or ☐ 300mg SubQ at week 12, then every 4 weeks
Tremfya (guselkumab)	Initial infusion: 200mg IV at 0, 4, and 8 weeks Maintenance*: ☐ 100mg SubQ at week 16, then every 8 weeks thereafter OR ☐ 200mg SubQ at week 12, then every 4 weeks thereafter
☐ Infliximab or infliximab biosimilar (as required by patient's insurance) ☐ Do not substitute. Infuse the following infliximab product: 	Dose: mg/kg IV Frequency: ☐ 0, 2, 6 then every 8 weeks ☐ Every weeks For Allied use only. Brand:

Premedications:

☐ Tylenol 650mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol IV 40mg, 125mg or mg
☐ Other: IV or PO

Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Prescriber Name (Please print): Contact Person:

Prescriber Signature: Date:

Please include a copy of the latest insurance information as well as all applicable clinical notes.

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.