Indiana University Health

Gastroenterology Home Health Infusion Referral

To: IU Health Home Care *infusionhomecare@iuhealth.org* **Fax (317) 962-4737 * Phone (317) 963-4919**	***For NON-IU HEALTH physician referrals, please attach patient demographics, insurance, and clinic notes.***
From: **Phone:** **Fax** :	**Today's Date:** **ICD-10/Diagnosis:**
Patient Name: **DOB:** **MRN:**	**Patient Weight:** _____**kg or**_____**pounds** **Patient Height:** _____**cm or**_____**inches**

☒ **Home Infusion Therapy and Skilled Nursing Visits** for *Administration/Assessment / Education*	
Entyvio, x1 year	First Dose: ☐ Yes ☐ No If NO, indicate when next dose is needed: Induction Dose: Week 2, Date Due:_____Week 6, Date Due: _____ Maintenance Dose: Date Due: _____ ☐ Induction Dose: Infuse 300mg IV at weeks 0, 2 and 6 ☐ Maintenance Dose: Infuse 300mg IV every 8 weeks
Stelara, x1 year	First Dose: ☐ Yes ☐ No If NO, indicate when next SC dose is needed: Date Due:_____ ☐ Intravenous Induction Dose: ☐ Patients weighing ≤ 55 kg, Infuse 260 mg (2 x130mg/26mL vials) IV at week 0 ☐ Patients weighing > 55 kg to 85 kg: Infuse 390 mg (3 x 130mg/26mL vials) IV at week 0 ☐ Patients weighing > 85 kg: Infuse 520 mg (4 x 130mg/26mL vials) IV at week 0 ☐ SC Maintenance Dose: Inject 90mg SC every 8 weeks
Infliximab (Remicade; Inflectra; Renflexis Avsola), x1 year	☐ Remicade ☐ Inflectra ☐ Renflexis ☐ Avsola First Dose: ☐ Yes ☐ No Indicate when next dose is needed if still in induction phase: Induction Dose: Week 2, Date Due:_____Week 6, Date Due:_____ Maintenance Dose: Date Due:_____ ☐ Induction Dose: Infuse 5mg/kg or_____mg/kg IV at weeks 0, 2 and 6 ☐ Maintenance Dose: Infuse_____mg/kg IV every 8 weeks OR_____mg/kg IV every_____weeks Infusion time: Infuse over_____hours if different than PI recommendation
Hypersensitivity Reaction/Treatment	☒ IUHHC Anaphylaxis Adverse Drug Reaction Protocol if required per Home Care Approved Medication policy. Pharmacy to dispense epinephrine, diphenhydramine, and Normal Saline per IUHHC protocol
IV Access	☐ PIV - RN to place peripheral line at home and discontinue once IV therapy completed ☐ Port – supplies and flushes per IUHHC catheter maintenance protocol
Labs	☐ Labs and frequency_____

Physician Name (printed) _____

Physician Signature_____Date _____