

Texas Centers for Infectious Disease Associates Pharmacy

FORT WORTH / 1025 College Ave., Fort Worth, TX 76104

Phone: 817-336-1640 Fax: 817-336-1643

DALLAS / 3410 Worth St., Ste. 780, Dallas TX 75246



Patient Information		Prescriber Information	
Patient name:		Prescriber name:	
DOB:	SSN:	DEA:	
Address:		NPI	License:
City:	State:	Zip:	
Phone #:		City:	State:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Fax:	

Insurance Information: Complete entirely and fax front and back of patient's insurance card					
Primary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Secondary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Prescription card:	Name of insurer:	ID:	BIN:	PCN:	Group:

ICD 10 and Diagnosis:	Patient History
ICD 10:	Weight <input type="checkbox"/> KG <input type="checkbox"/> LB Height <input type="checkbox"/> IN <input type="checkbox"/> CM
Diagnosis:	<input type="checkbox"/> NKDA <input type="checkbox"/> Allergies:

Provider Orders:					
	Drug	Dose	Directions	QTY	Refills
MEDICATION	<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300mg	<input type="checkbox"/> Induction <input type="checkbox"/> weeks, 0, 2 and 6 <input type="checkbox"/> Maintenance <input type="checkbox"/> Q8weeks <input type="checkbox"/> other Q_____ weeks		
	Pre-medication	<input type="checkbox"/> Acetaminophen 325 mg PO <input type="checkbox"/> Dexamethasone 4mg IVP	<input type="checkbox"/> Diphenhydramine 25 mg PO <input type="checkbox"/> Methylprednisolone 40mg IVP	<input type="checkbox"/> Diphenhydramine 25 mg IV <input type="checkbox"/> Other: _____	

LABS	
Baseline labs on admission and then drawn weekly while on therapy	<input type="checkbox"/> CBC with differential <input type="checkbox"/> CMP <input type="checkbox"/> CRP Quant <input type="checkbox"/> ESR <input type="checkbox"/> CK <input type="checkbox"/> Entyvio trough prior to 4 th infusion <input type="checkbox"/> Other: _____

Nursing: Evaluate and teach patient administration of IV medication, provide IV-line dressing change weekly and PRN, use SASH flushing protocol: S- Saline 10ml, A- administration medication, S- saline 10ml, H-Heparin 5ml (100units/ml). When on more than one dose per day patient to alternate lumens for administration

Prescriber Authorization: I authorize this pharmacy and its representative to act as my agent to secure coverage, dose IV meds based on labs and weight, provide supplies necessary for infusion and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber signature: _____ Date: _____