Mercy LTC & Specialty Pharmacy
A Member of Mercy Pharmacy Group

FAX: 562.402.4629

GASTROENTEROLOGY

Version: 2/12/2025

PATIENT INFORMATION

Patient Name: DOB: Patient Phone:

Allergies: Weight lbs/kg: Height:

DIAGNOSIS

Diagnosis/ICD 10:

Documentation

◯ Demographic info, H&P, insurance info, labs results, 2-3 clinical visit notes (as appropriate)
IV line
Flushing Protocol:

Skilled Nursing Care: Providing medication(s) via venous access or subcutaneous access in accordance with medication orders. Evaluation and documentation of health status, therapy response, and educational needs. Provide support and assistance as required.

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	REFILLS
SKYRIZI® **Check for SQ and IV**	◯ 600 mg for Crohn's ◯ 1,200 mg for UC	**Initial Dose:** ◯ at week 0, 4, and 8	**Initial** _____ vials	
	◯ 90 mg/mL PF syringe ◯ 180 mg/1.2mL cartridge ◯ 350 mg/2.4 mL PF _____	**Maintenance Dose:** ◯ _____ mg SQ on week 12 then every 8 weeks	**Maintenance** #	
STELARA®	◯ 130mg/26mL vial	◯ _____ mg IV Once	**Initial:** #	
	◯ 45 mg/0.5 mL PF Syringe ◯ 90 mg/mL PF Syringe	**Maintenance Dose:** ◯ _____ mg SQ every 8 weeks after initial dose	**Maintenance** ◯ 1 box	
HUMIRA®	◯ Humira Starter Kit ◯ Adult Crohn's, UC start kit ◯ Pediatric Crohn's start kit	**Initial Dose:** ◯ 160 mg SQ on day 1, then 80 mg on day 15, ◯ 80 mg SQ on day 1, then 40 mg on day 15	**Initial** ◯ 1 kit	
	◯ Pen ◯ Prefilled Syringe ◯ Citrate free	**Maintenance Dose:** ◯ _____ mg SQ every _____ week start on day 29	**Maintenance** _____ weeks	
◯ **REMICADE** ◯ **INFLECTRA** ◯ **RENFLEXIS** ◯ **INFLIXIMAB**	◯ 100 mg vial (Round the dose as per closest vial sizes)	**Initial Dose:** ◯ 5 mg/kg = mg IV at week 0, 2, and 6	**Initial** #:	
		Maintenance Dose: ◯ _____ mg IV every 8 weeks	**Maintenance** #	
RINVOQ ER TABLET	◯ 15 mg ◯ 30 mg ◯ 45 mg	**Loading Dose:** ◯ Daily orally for _____ weeks	**Loading** ◯ _____ tabs	
		Maintenance Dose: ◯ Daily orally for _____ weeks	**Maintenance** ◯ _____ tabs	
TREMFYA®	◯ 200 mg vial ◯ 100 mg/mL PF syringe ◯ 200 mg/2 mL PF syringe ◯ 100 mg/mL Pen	**Initial Dose:** ◯ Infuse 200 mg IV at week 0, 4, and 8	**Initial** #	

	○ 200 mg/2mL Pen	**Maintenance Dose:** ○ 100 mg SQ every 8 weeks starting week 16 ○ 200 mg SQ every 8 weeks starting week 12	**Maintenance** #	
TYSABRI®	○ 300 mg/15 mL vial	○ Infuse 300 mg IV every 4 weeks	**Quantity** #	
OTHER				

PROVIDER INFORMATION

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Provider/Practice Name: Contact Person:

Provider NPI: Phone: Fax:

Provider Signature **DAW (Dispense as Written)** **Date**

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