

GASTROENTEROLOGY INFUSION REFERRAL FORM

PHONE 855.896.9254 | FAX 855.370.0086



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (if applicable)			Alt Contact Email	Alt Contact Phone	

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Referral Contact Email	Office Phone	Office Fax			
Practice / Facility Name	Prescriber Name / Specialty				
Address	City	State	ZIP		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment <input type="checkbox"/>	Therapy Start Date			
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Therapies Tried and Failed (please list medications)				
Other/Concomitant Medications (please list)				
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)				
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)				
ICD-10 Code <input type="checkbox"/> K50.90 Crohn's disease unspecified without complications <input type="checkbox"/> Other _____ <input type="checkbox"/> K51.90 Ulcerative colitis, unspecified, without complications				

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Entyvio (vedolizumab)	<input type="checkbox"/> IV	Starting Dose <input type="checkbox"/> Infuse 300 mg IV at weeks 0, 2, 6 and then every 8 weeks thereafter Maintenance Dose <input type="checkbox"/> Infuse 300 mg IV every 8 weeks	<input type="checkbox"/> Reconstitute each vial of Entyvio with 4.8 mL of sterile water and dilute in 250 mL of NS or sterile Lactated Ringers. Infuse over 30 minutes	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Remicade (infliximab)	<input type="checkbox"/> IV	Starting Dose 100 mg vial <input type="checkbox"/> None <input type="checkbox"/> 5 mg/kg Pt weight____(kg) = ____mg IV every 8 weeks Maintenance dose 100 mg vial <input type="checkbox"/> 5 mg/kg Pt weight____(kg) = ____mg IV every 8 weeks <input type="checkbox"/> Other _____	<input type="checkbox"/> Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired doses in NS 250 mL to be infused over a period NOT less than 2 hours. <input type="checkbox"/> Additional directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Stelara (ustekinumab)	<input type="checkbox"/> IV	Loading Dose <input type="checkbox"/> Infuse 260 mg IV at week 0 (55kg or less) <input type="checkbox"/> Infuse 390 mg IV at week 0 (85kg >55kg) <input type="checkbox"/> Infuse 520 mg IV at week 0 (>85 kg) Maintenance Dose <input type="checkbox"/> Inject 90 mg subcutaneously every 8 weeks (start 8 weeks after infused loading dose)	Loading Dose Dilute the desired dose in 250 mL of NS. Infuse over a period of at least an hour	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____

<input type="checkbox"/> Vascular Access Method <input type="checkbox"/> peripheral <input type="checkbox"/> central <input type="checkbox"/> other: _____					
<input type="checkbox"/> Normal Saline <input type="checkbox"/> DSW	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Heparin 10 units/mL <input type="checkbox"/> Heparin 100 units/mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> PRN Allergic Reaction: _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg <input type="checkbox"/> 1 gm <input type="checkbox"/> _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30kg/>66lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Other:	<input type="checkbox"/> _____				

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	NPI #	Date
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)		

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

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