GASTROENTEROLOGY INFUSION REFERRAL FORM

PHONE 855.896.9254 | **FAX** 855.370.0086

AMBER SPECIALTY PHARMACY

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 ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ 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) ☐ Email ☐ Phone ☐ 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 ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			Therapy Start Date	
Sample/Starter Provided? ☐ No ☐ 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 ☐ NKDA ☐ Drug Allergies (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				
ICD-10 Code ☐ K50.90 Crohn's disease unspecified without complications ☐ K51.90 Ulcerative colitis, unspecified, without complications		☐ Other _____		

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
☐ Entyvio (vedolizumab)	☐ IV	Starting Dose ☐ Infuse 300 mg IV at weeks 0, 2, 6 and then every 8 weeks therafter Maintenance Dose ☐ Infuse 300 mg IV every 8 weeks	☐ 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	☐ _____	☐ 1 year ☐ _____
☐ Remicade (infliximab) Biosimilars: ☐ Avsola ☐ Inflectra ☐ Infliximab ☐ Renflexis	☐ IV	Starting Dose 100 mg vial ☐ None ☐ 5 mg/kg Pt weight___(kg) =____mg IV every 8 weeks Maintenance dose 100 mg vial ☐ 5 mg/kg Pt weight___(kg) =____mg IV every 8 weeks ☐ Other _____	☐ Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired does in NS 250 mL to be infused over a period NOT less than 2 hours. ☐ Additional directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) _____	☐ _____	☐ 1 year ☐ _____
☐ Stelara (ustekinumab	☐ IV	☐ 130 mg/26 mL Vial (weight-based) Current Weight: _____ kg	Induction Dose: Infuse: ☐ ≤55 kg: 260 mg IV as a single dose ☐ >55 kg to 85 kg: 390 mg IV as a single dose ☐ >85 kg: 520 mg IV as a single dose	2 Vials 3 Vials 4 Vials	0
	☐ SUBQ	☐ 90 mg/1 mL PFS	Maintenance Dose: ☐ Inject 90 mg SubQ 8 weeks after first IV dose, then every 8 weeks thereafter	1	
☐ Vascular Access Method ☐ peripheral ☐ central ☐ other: _____					
☐ Normal Saline ☐ D5W	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Diphenhydramine	☐ PO ☐ IV ☐ IM	☐ 25 mg ☐ 50 mg ☐ _____	☐ After infusion ☐ PRN Allergic Reaction: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 500 mg ☐ 650 mg ☐ 1 gm ☐ _____	☐ Pre-Med: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000, 0.3 mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	☐ 1 year ☐ _____
☐ Other:	☐ _____				

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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