GASTROENTEROLOGY REFERRAL FORM (A-R)

PHONE 888.370.1724 | **FAX** 877.645.7514



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	1											
Last Name	First Name	DOB		Gender □ M	□F	Last 4 SSN		Primary	Language			
Address			City				State		ZIP			
Email	Home F	Phone		Work Phor	ne			Cell	Phone			
Primary Contact Method (chec	ck one) 🗆 Cell Phone 🗆	Home Phone ☐ Work Ph	one 🗆 Te	ext 🗆 Email	☐ Priı	mary Caregiver	□ DO	NOT CONTAC	СТ			
Primary Caregiver/Alt Contact	Name (If applicable)	Alt Co	ntact Emai	il				Alt Con	tact Phone			
PRESCRIBER INFORMA	TION											
Name of Contact Sending Refe		Title			Prefe	rred Contact Met	hod (ch	eck one)	Email □ Ph	one	□ Fax	
Referral Contact Email				Office Phone				Office Fax				
Practice / Facility Name				Prescriber Nar	ne / S	specialty						
Address			(City				State		ZIP		
Prescriber State License #	DEA #		NI					Medicaid UPII	N #			
	* Please	include a copy of t	the froi	nt and back	of i	nsurance ca	rd *					
CLINICAL INFORMATIO												
Patient New to Therapy ☐ New	Start	☐ Existing Treatment	Therapy	Start Date		ICD-10 Code:		Dlagnosis	:			
Sample/Starter Provided? □ N	o ☐ Yes, Provide Qty:	Date Provided:	F	Patient Height (cn	n/in):	Weight	(kg/lbs): [Date Obtained:			
TB Test Results:	Test Date:	Hepatitis B ruled out? □ Y	es 🗆 No	If no, has treatme	ent be	een started? 🗆 Y	es 🗆 No)				
If Self-injectable drug, is inject	ion training coordination rec	quired by our pharmacy?	Yes □ No)		Does patient hav	e a late	x allergy?	Yes □ No			
Therapies Tried and Failed (ple	ease list medications)											
Other/Concomitant Medication	ns (please list)											
Allergies □ NKDA □ Drug A	Allergies (please list)			☐ Other Aller	gies (please list)						
Ship to Address ☐ Home ☐	Prescriber's Office Oth	ner (please list)										
PRESCRIPTION INFORM			te law									
In order for a brand name p or your state-specific requir									ons			
			is flot a v	and prescription	JII TOI	in for writing c	OI ILI OIII	eu meaican	QTY		DEFULC	
MEDICATION	DOSE	DIRECTIONS Starter Descriptions	400 mg (2v200 ma injectio	v/200 mm injections) Sub-Oat Weeks 0. 2 and 4						REFILLS	
☐ Cimzia (Note: Cimzia vials should be prepared and administered	☐ 200 mg/mL PFS ☐ 200 mg Vial	-	Starter Dose: Inject 400 mg (2x200 mg injections) SubQ at Weeks 0, 2 and 4 Maintenance Dose: Inject 400 mg (2x200 mg injections SubQ every 4 weeks									
by a health care professional) □ Dupixent	□ 300mg/2mL PFS	Inject 300mg SubQ o	Inject 300mg SubQ once weekly									
D Fatania	□ 300mg/2mL PEN	Charter Danie Clarker										
☐ Entyvio	☐ 300 mg Vial ☐ MD Office infusion		Starter Dose: ☐ Infuse 300 mg IV at Week 0, 2 and 6								0	
Ultimatica CD/UC/UC Showbay	☐ Home Infusion	Maintenance Dose:	Maintenance Dose: ☐ Infuse 300 mg IV every 8 weeks									
☐ Humira CD/UC/HS Starter	80mg/0.8mL Pen											
☐ Humira CF	□ 80 mg/0.8 mL Pen			ns) SubQ on Day 1, then 80 mg SubQ on Day 15 Day 2, Then 80 mg SubQ on Day 15					ens	0		
	☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL PFS	Maintenance Dose: ☐ Inject 40 mg SubQ on Day 29 & every other week thereafter								2		
□ Remicade □ Avsola	☐ 100 mg Vial ☐ MD Office infusion	Starter Dose: 5 mg/kg 10 mg/kg Infuse mg IV on Weeks 0, 2 & 6									0	
☐ Inflectra ☐ Infliximab ☐ Renflexis	☐ Home Infusion Current Weight:k	_kg Maintenance Dose: □ 5 mg/kg □ 10 mg/kg Infuse mg IV every weeks										
□ Rinvoq	☐ 45mg XR tablet	Induction dose: ☐ 45mg PO once daily for 8 weeks							5	6	0	
□ 15mg XR tablet Maintenance dose: □ 30mgXR tablet □ 15mg PO once daily □ 30mg PO once daily								3	0			
Prescriber Signature		Date				Signature (where	require	d by state law	/) Date			
DAW (Dispense as Written)		Date		Brand Necessary	(must	ı nanawrite)						

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.

GASTROENTEROLOGY REFERRAL FORM (S-X)

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PATIENT INFORMATION	1											
Last Name	First Name	DOB		G	Sender □ M	□F	Last 4 SSN		Prin	nary Lang	uage	
Address			Ci	ity				State		z	ZIP	
Email	Home Pho			Work Ph	one				Cell Phone	е		
Primary Contact Method (chec	ck one) Cell Phone Ho	me Phone	Phone [□ Text	□ Email	□ Pr	imary Caregiver	□ DO N	OT CON	NTACT		
Primary Caregiver/Alt Contact	Name (If applicable)	Alt	Contact E	mail					Alt	Contact P	hone	
PRESCRIBER INFORMA	TION											
Name of Contact Sending Refe	erral	Title				Pref	erred Contact Met	thod (ched	ck one)	□ Email	I ☐ Phone	□ Fax
Referral Contact Email					Office Phone	•		(Office Fa	эx		
Practice / Facility Name					Prescriber N	ame /	Specialty					
Address				City	у				St	tate	ZIF	•
Prescriber State License #	DEA#			NPI	l #			М	edicaid (UPIN#		
	* Please in	clude a copy o	of the fi	ront	and bac	k of	insurance ca	ard *				
CLINICAL INFORMATIO	N - Please include appl	icable clinical ch	nart note	es								
Patient New to Therapy ☐ New	v Start □ Therapy Restart □	Existing Treatment	Thera	apy Sta	art Date		ICD-10 Code:		Dlagn	osis:		
Sample/Starter Provided? ☐ N	o ☐ Yes, Provide Qty:	Date Provided:		Pat	ient Height (cm/in)	: Weight	(kg/lbs):		Date C	Obtained:	
TB Test Results:	Test Date: He	epatitis B ruled out?	□ Yes □ N	lo If	no, has treat	ment b	een started? 🗆 Y	es □ No				
If Self-injectable drug, is inject	ion training coordination requi	ed by our pharmacy?	P □ Yes □	□No			Does patient hav	e a latex	allergy?	☐ Yes ☐	No	
Therapies Tried and Failed (ple	ease list medications)						L					
Other/Concomitant Medication	ns (please list)											
Allergies □ NKDA □ Drug A	Allergies (please list)				☐ Other All	ergies	(please list)					
Ship to Address ☐ Home ☐	☐ Prescriber's Office ☐ Other	(please list)										
PRESCRIPTION INFORM	ATION - Please Escrib	e if required by	state lav	N								
In order for a brand name p or your state-specific requir										cations		
MEDICATION	DOSE DOSE	DIRECTIONS	III IS IIOC	a vaii	iu prescript	1011 10	illi for writing c	Ontrollec	i mean	sations.	QTY	REFILLS
□ Simponi	□ 100 mg/mL SmartJect	Starter Dose: Inject	t 200 mg	(2×10)	ng injectio	nc) Sul	hO at Wook O and	100 mg 9	SubO at	Wook 2	3	REFILLS 0
- Simponi	□ 100 mg/mL PFS	Maintenance Dose						100 mg s	Juba at	Week 2	1	
□ Skyrizi	□ 600mg/10mL SDV	Induction Dose: ☐ 600mg IV at we	ek 0,4, and	d 8							3 Vials	
	☐ 180mg/1.2mL Cartridge with On-Body injector ☐ 360mg/2.4mL Cartridge with On-Body injector	□ 180mg SubQ at week 12 and every 8 weeks thereafter □ 350mg SubQ at week 12 and every 8 weeks thereafter								1		
□ Stelara Note: Stelara is intended for use under the guidance and supervision of a physician with patients who will be closely monitored and have regular follow-up. Patients may self-inject with Stelara after physician approval and proper training. Administration: □ MD Office □ Self-Administration	□ 130 mg/26 mL Vial (weight-based) Current Weight: kg	Induction Dose: Infuse: ☐ <55 kg: 260 mg IV as a single dose ☐ >55 kg: 0 85 kg: 390 mg IV as a single dose ☐ >85 kg: 520 mg IV as a single dose								2 Vials 3 Vials 4 Vials	o	
	□ 90 mg/1 mL PFS	Maintenance Dose: ☐ Inject 90 mg SubQ 8 weeks after first IV dose, then every 8 weeks thereafter								1		
□ Xeljanz	□ 10 mg Tablet □ 22 mg XR Tablet	Induction Dose: ☐ Take 10 mg by mouth twice daily x8 weeks ☐ Take 22 mg by mouth once daily x8 weeks							56 28	1		
	□ 5 mg Tablet □ 10 mg Tablet □ 11 mg XR Tablet □ 22 mg XR Tablet	Maintenance Dose: Take 5 mg by mouth twice daily Take 10 mg by mouth twice daily Take 11 mg by mouth once daily Tale 22 mg by mouth once daily								60 60 30 30		
Prescriber Signature		Date					Signature (where	required	by state	· law)	Date	
DAW (Dispense as Written)		Date				, ,						

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GASTROENTEROLOGY REFERRAL FORM (Y-Z)

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Kemove above po	ortion before tax	irig. Fiease	complete the prest	cription roi	,,,,,	its entirety ai	IG TAX WILL	rsecur	e cove	SHEEL LO) the m	urriber above.		
PATIENT INFORMATION	l e													
Last Name	First Nam	е	DOB		Gen	der 🗆 M 🗆 F	Last 4 S	SN		Prim	nary Lan	guage		
Address				City	_		'		State			ZIP		
Email		Home Pho	ne			Work Phone		,		(Cell Phor	ne		
Primary Contact Method (chec	k one) 🗆 Cell Pho	one 🗆 Hor	me Phone	Phone 🗆 T	Text	□ Email □ P	rimary Care	giver	□ DO	NOT CON	ITACT			
Primary Caregiver/Alt Contact	Name (If applicable	e)	Alt C	Contact Ema	ail					Alt 0	Contact	Phone		
PRESCRIBER INFORMA	TION													
Name of Contact Sending Refe	rral		Title			Pre	ferred Cont	act Met	hod (ch	eck one)	□ Ema	ail 🗆 Phone	□ Fax	
Referral Contact Email			'		Off	fice Phone				Office Fa	ıx			
Practice / Facility Name					Pre	escriber Name /	Specialty		<u>'</u>					
Address				City	City				St	ate	ZIP			
Prescriber State License #	DE	EA #		1	NPI#				ı	Medicaid (JPIN#	-		
	* <i>P</i>	Please in	clude a copy of	f the fro	nt ai	nd back of	insuran	ice ca	rd *					
CLINICAL INFORMATIO	N - Please incl	ude appli	icable clinical cha	art notes	;									
Patient New to Therapy ☐ New	Start 🗆 Therapy	Restart 🗆	Existing Treatment	Therapy	/ Start	Date	ICD-10 C	Code:		Dlagno	osis:			
Sample/Starter Provided? ☐ N	o □ Yes, Provide Q	ty:	Date Provided:	1	Patien	Patient Height (cm/in): Weight			t (kg/lbs): Date			Obtained:		
TB Test Results:	Test Date:	He	epatitis B ruled out?	Yes □ No	If no,	, has treatment	been starte	d? □ Ye	es 🗆 No)				
If Self-injectable drug, is injecti	on training coordin	ation require	ed by our pharmacy?	□ Yes □ N	10		Does pat	ient hav	e a late	allergy?	☐ Yes	□ No		
Therapies Tried and Failed (ple	ase list medications	s)					1							
Other/Concomitant Medication	s (please list)													
Allergies □ NKDA □ Drug A	Allergies (please list	t)				Other Allergies	(please list	t)						
Ship to Address ☐ Home ☐	Prescriber's Office	e 🗆 Other	(please list)											
PRESCRIPTION INFORM In order for a brand name p or your state-specific requir	roduct to be disp	pensed, the	e prescriber must ha	andwrite "l							cations.			
MEDICATION	DOSE		DIRECTIONS									QTY	REFILLS	
□ Zeposia Starter Kit Rx is only for on-label patients who will not receive a 37-day sample from their prescriber.	dy initiated date: kip to ion)	□ Titration Dose - For New Patients: Days 1-4: 0.23 mg capsule by mouth once daily (4 caps) Days 5-7: 0.46 mg capsule by mouth once daily (3 caps) Day 8 and thereafter: 0.92 mg capsule by mouth once daily (30 caps) □ Titration Dose - For Patients Restarting: Days 1-4: 0.23 mg capsule by mouth once daily (4 caps) Days 5-7: 0.46 mg capsule by mouth once daily (3 caps) Starter Pack sent to: □ Prescriber address □ Patient Address (if assessments are completed)						eleted)	1	0				
	□ 0.92 mg Capsule Maintenance Dose: □ Take 0.92 mg capsule by mouth once daily									30				
Prescriber Signature			Date		Super	rvising Physicia	n Signature	(where	require	d by state	law)	Date		
					Brand	Necessary (mi	ist handwrit	te)						

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