

Gastroenterology Referral Form

Fax completed form to: 833-908-1122



PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	Male Female
Patient Diagnosis & ICD-10:		
Allergies:		
PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		
PLEASE ATTACH		
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Line access documentation/verification if applicable Vaccine status (any vaccination) and documentation of any recent vaccinations		TB lab results within last 12 months HBV lab results within last 12 months (<i>Infliximabs only</i>) Liver enzymes lab results (<i>Skyrizi only</i>) Bilirubin levels (<i>Skyrizi only</i>) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines
NURSING & LAB ORDERS		
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders:		
Lab Date & Frequency:		
PRESCRIPTION ORDERS		
Anaphylaxis Kit:	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV as needed
(Check all that apply)	Diphenhydramine _____ mg IV as needed	NS Hydration 500 ml IV over 30 minutes as needed
		Solu-Medrol 60mg - 125mg IV as needed
Pre-Medications:	Acetaminophen _____ mg PO _____ minutes prior to infusion	Solu-Medrol _____ mg IV _____ minutes prior to infusion
(Check all that apply)	Diphenhydramine _____ mg PO ---OR--- IV _____ minutes prior to infusion	Other _____
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary		
PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose? Yes No If No, when was last dose given? _____ When is patient due for next dose? _____		
ENTYVIO	Induction: 300mg IV infusion via gravity ---OR--- pump over 30 minutes at week 0, 2, and 6 Maintenance: 300mg IV infusion via gravity ---OR--- pump over 30 minutes every _____ weeks	NONE
INFLIXIMAB Avsola Inflixtra Remicade Renflexis	Induction: _____ mg/kg or _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours at weeks 0, 2, and 6 Maintenance: _____ mg/kg _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours every _____ weeks (Note: Round to nearest 100mg for Medicaid patients) If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert.	NONE
SKYRIZI	Induction: 600mg IV infusion via gravity ---OR--- pump over one hour at week 0, 4, and 8 Maintenance: 360mg SC injection at Week 12, and every 8 weeks thereafter	NONE
STELARA	Induction (Adult Dosing -Based on body weight of patient at time of dosing): For patients 55kg or less administer 260mg IV infusion via gravity ---OR--- pump over at least 1 hour x 1 dose For patients more than 55kg to 85kg administer 390mg IV infusion via gravity ---OR--- pump over at least 1 hour x 1 dose For patients more than 85kg administer 520mg IV infusion via gravity ---OR--- pump over at least 1 hour x 1 dose Maintenance: 90mg SubQ injection _____ weeks after induction and every _____ weeks thereafter	NONE
OTHER		NONE
<i>By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.</i>		

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date