

Gastroenterology Referral Form



Fax Completed Form To:

Phone:

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.	
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: (Check all that apply)	Epinephrine 0.3mg IM as needed Diphenhydramine _____ mg IV as needed	Solu-cortef 250mg-500mg IV as needed NS Hydration 500 ml IV over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV as needed Other _____
Pre-Medications: (Check all that apply)	Acetaminophen _____ mg PO _____ minutes prior to infusion Diphenhydramine _____ mg PO ---OR--- IV _____ minutes prior to infusion	Solu-Medrol _____ mg 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? _____		
CIMZIA®	200x2 Prefilled Syringe 200x2 LYO Powder	Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 Inject 400mg subcutaneously once every 4 weeks	1 Kit 4 week supply
ENTYVIO	Induction: 300mg IV infusion over 30 minutes at week 0 and 2 Maintenance: 300mg IV infusion over 30 minutes every _____ weeks --OR-- Prefilled Pen 108mg SC every 2 weeks starting at week 6		NONE _____ 2 pens, 13 refills
HUMIRA® Citrate-Free	Crohn's/UC Starter Package (8mg-80mg Pens) 40mg Pen 40mg PFS	Inject 160mg given as Two 80mg SubQ Day 1 --OR-- One 80mg SubQ Days 1 & 2, then Week 2 inject 80 mg subcutaneously on Day 15 Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply
INFLIXIMAB Avsola Inflectra Remicade Renflexis	Induction: _____ mg/kg or _____ mg IV infusion over at least 2 hours at weeks 0, 2, and 6 Maintenance: _____ mg/kg _____ mg IV infusion 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 _____ _____
OMVOH	Induction: 300mg IV infusion over 30 minutes at week 0, 4, and 8 Maintenance: 200mg SC injection (given as two consecutive injections of 100 mg each) at Week 12, and every 4 weeks thereafter		NONE _____
SKYRIZI	Induction: 600mg IV infusion 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 over at least 1 hour x 1 dose For patients more than 55kg to 85kg administer 390mg IV infusion over at least 1 hour x 1 dose For patients more than 85kg administer 520mg IV infusion over at least 1 hour x 1 dose Maintenance: 90mg SubQ injection _____ weeks after induction and every _____ weeks thereafter		NONE _____ _____
OTHER			NONE _____

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.

Prescriber's Signature _____
Dispense as Written _____
Print Name _____
Date _____

Prescriber's Signature _____
Substitution Permitted _____
Print Name _____
Date _____



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