Gastroenterology Referral Form

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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 *(Infliximabs only)*
- ☐ Liver enzymes lab results *(Skyrizi only)*
- ☐ Bilirubin levels *(Skyrizi only)*
- ☐ 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: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed
☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV ____minutes prior to infusion
☐ 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 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
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ **Induction**: _____mg/kg or _____mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 2 hours at weeks 0, 2, and 6	NONE
	☐ **Maintenance**: _____mg/kg _____ mgIV 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.	_____
☐ OMVOH	☐ **Induction**: 300mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over 30 minutes at week 0, 4, and 8	NONE
	☐ **Maintenance**: 200mg SC injection (given as two consecutive injections of 100 mg each) at Week 12, and every 4 weeks thereafter	_____
☐ SKYRIZI	☐ **Induction**: 600mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over one hour at week 0, 4, and 8	NONE
	☐ **Maintenance**: 360mg SC injection at Week 12, and every 8 weeks thereafter	_____
☐ 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	NONE
	☐ **Maintenance**: 90mg SubQ injection _____ weeks after induction and every _____ weeks thereafter	_____
☐ 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 **Print Name** **Date**
Dispense as Written

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

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