Gastroenterology Referral Form





Fax Completed Form To:

Phone:

		PATII	ENT 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:					
		PROV	IDER INFORMATION		
Physician Name:		Lic.#:		DEA #:	
Practice Name:				NPI#:	
Address:				City/State/Zip:	
		Phone:		Fax:	
Supervisory Physician (if applicable):					
PLEASE ATTACH					
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical) ☐ TB lab results within last 12 months ☐ UNIV leb results within last 13 months (Individually a physical lab & partition) to resedue results.					
☐ Recent office visit notes, history & physical, lab & pertinent procedure results ☐ Current medication list & list of prior medications tried and failed (with dates) ☐ Liver enzymes lab results (Skyrizi only)					
☐ Current medication list & list of prior medications tried and failed (with dates) ☐ Line access documentation/verification if applicable ☐ Liver enzymes lab results (Skyrizi only) ☐ Bilirubin levels (Skyrizi only)					
	vaccination) and documentation of any recen	t vaccinations		ty if drug dosing or indication is outside of FDA guidelin	nes
NURSING & LAB ORDERS					
Nurse Orders: Nurse to	provide assessment teaching lab draws me			tion and/or management per physician orders.	
Flush Orders: NaCl 0 99	% – 5–10ml flush pre and post infusion and as	needed <i>Henarin</i> - \Box	10units/ml 0R	its/mL - 3-5mL flush after post-infusion NS flush if ind	icated to maintain line
Lab Orders:	5 Tome hash pre and post imasion and as	niceaea riepann 🗀	Lab Date & Frequency:	instruction post infusion to master mus	reace to maintain inc
		PRES	CRIPTION ORDERS		
Anaphylaxis Kit:	☐ Epinephrine 0.3mg IM as needed			ded Solu-Medrol 60mg -	125mg IV as needed
Anaphylaxis Kit:					
Pre-Medications: Acetaminophenmg P0minutes prior to infusion					
(Check all that apply)					
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary					
PRODUCT		PRESCRI	TION INFORMATION		REFILLS
Is this a first dose?	Yes □ No If No, when was last dose giver				
is this a hist dose:	ics in the intro, which was last dose given		When is nationt due for nevi	· doce?	
			When is patient due for next	dose?	NONE
C FNTVARO	☐ Induction: 300mg IV infusion over 30 r		_ '	dose?	NONE
□ ENTYVIO	☐ Maintenance: 300mg IV infusion over	ninutes at week 0, 2, ar	_ '	dose?	
	<u> </u>	ninutes at week 0, 2, ar	nd 6	dose?	NONE 2 pens, 13 refills
☐ INFLIXIMAB	☐ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week	ninutes at week 0, 2, ar 30 minutes every s starting at week 6	nd 6	over at least 2 hours at weeks 0, 2, and 6	2 pens, 13 refills
☐ INFLIXIMAB	☐ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week☐ Induction:mg/kg or	minutes at week 0, 2, ar 30 minutes every s starting at week 6 mg IV infusion via	ond 6 weeks gravity OR pump	over at least 2 hours at weeks 0, 2, and 6	
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra	□ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week □ Induction:mg/kg or □ Maintenance:mg/kg	ninutes at week 0, 2, ar 30 minutes every s starting at week 6 mg IV infusion via mgIV infusion via	ond 6 weeks gravity OR pump		2 pens, 13 refills
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra ☐ Remicade	□ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week □ Induction:mg/kg or □ Maintenance:mg/kg (Note: Round to nearest 100mg for Medicaid p	minutes at week 0, 2, ar 30 minutes every s starting at week 6 mg IV infusion via mgIV infusion via patients)	weeks gravity OR pump gravity OR pump	over at least 2 hours at weeks 0, 2, and 6	2 pens, 13 refills
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra	□ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week □ Induction:mg/kg or □ Maintenance:mg/kg	minutes at week 0, 2, ar 30 minutes every s starting at week 6 mg IV infusion via mgIV infusion via patients)	weeks gravity OR pump gravity OR pump	over at least 2 hours at weeks 0, 2, and 6	2 pens, 13 refills
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	□ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week □ Induction:mg/kg or □ Maintenance:mg/kg (Note: Round to nearest 100mg for Medicaid p	minutes at week 0, 2, ar 30 minutes every s starting at week 6 mg IV infusion via mgIV infusion via patients) on time according to ma	weeks gravity <i>OR</i> pump gravity <i>OR</i> pump gravity <i>OR</i> pump	over at least 2 hours at weeks 0, 2, and 6 over at least 2 hours every weeks	2 pens, 13 refills
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra ☐ Remicade	□ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week □ Induction:mg/kg or □ Maintenance:mg/kg (Note: Round to nearest 100mg for Medicaid p	minutes at week 0, 2, ar 30 minutes every s starting at week 6 mg IV infusion via mgIV infusion via patients) on time according to ma	weeks gravity <i>OR</i> pump gravity <i>OR</i> pump gravity <i>OR</i> pump	over at least 2 hours at weeks 0, 2, and 6 over at least 2 hours every weeks	2 pens, 13 refills NONE
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	□ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week □ Induction:mg/kg or □ Maintenance:mg/kg (Note: Round to nearest 100mg for Medicaid p	ninutes at week 0, 2, ar 30 minutes every s starting at week 6mg IV infusion viamgIV infusion via patients) on time according to magravityOR p	weeks gravityOR pump gravityOR pump gravityOR pump anufacturer package insert. gravity over 30 minutes at week 0,	over at least 2 hours at weeks 0, 2, and 6 over at least 2 hours every weeks 4, and 8	2 pens, 13 refills NONE
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	□ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week □ Induction:mg/kg or □ Maintenance:mg/kg(Note: Round to nearest 100mg for Medicaid p. If Remicade infusion tolerated, adjust infusion □ Induction: 300mg IV infusion via □ □ Maintenance: 200mg SC injection (given the second of	minutes at week 0, 2, ar 30 minutes every s starting at week 6mg IV infusion viamglV infusion via patients) on time according to ma gravityOR	weeks gravityOR pump gravityOR pump gravityOR pump anufacturer package insert. gravity or 30 minutes at week 0, njections of 100 mg each) at Week	over at least 2 hours at weeks 0, 2, and 6 over at least 2 hours every weeks 4, and 8 ek 12, and every 4 weeks thereafter	2 pens, 13 refills NONE NONE NONE
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	□ Maintenance: 300mg IV infusion overOR Prefilled Pen 108mg SC every 2 week □ Induction:mg/kg or □ Maintenance:mg/kg(Note: Round to nearest 100mg for Medicaid p. If Remicade infusion tolerated, adjust infusion Induction: 300mg IV infusion via □ Induction: 300mg IV infusion via □ Induction (Crohn's): 600mg IV infusion	minutes at week 0, 2, ar 30 minutes every s starting at week 6mg IV infusion viamglV infusion via patients) on time according to ma gravityOR	weeks gravityOR pump gravityOR pump anufacturer package insert. gravity over 30 minutes at week 0, njections of 100 mg each) at Week gravityOR pump	over at least 2 hours at weeks 0, 2, and 6 over at least 2 hours every weeks 4, and 8 ek 12, and every 4 weeks thereafter week 0, 4, and 8	2 pens, 13 refills NONE
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Prescriber's Signature <u>Dispense</u> as Written

Print Name

Date

Prescriber's Signature Substitution Permitted

Print Name

Date





