

Gastroenterology Referral Form

Fax Completed Form To: 877-418-4495 Phone: 877-418-4114



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: (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? _____
ENTYVIO	Induction: 300mg IV infusion via gravity ---OR--- pump over 30 minutes at week 0, 2, and 6		NONE
	Maintenance: 300mg IV infusion via gravity ---OR--- pump over 30 minutes every _____ weeks		_____
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		NONE
	Maintenance: _____ mg/kg _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours every _____ weeks <i>(Note: Round to nearest 100mg for Medicaid patients)</i>		_____
	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 _____
Dispense as Written

Print Name

Date

Prescriber's Signature _____
Substitution Permitted

Print Name

Date



ACHC ACCREDITED

