

# Gastroenterology Referral Form



Fax Completed Form To: 833-433-7975

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			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
<b>Flush Orders:</b> 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			
<b>Lab Orders:</b>		<b>Lab Date &amp; Frequency:</b>	
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b>	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV as needed	Solu-Medrol 60mg - 125mg IV as needed
(Check all that apply)	Diphenhydramine _____ mg IV as needed	NS Hydration 500 ml IV over 30 minutes as needed	Other _____
<b>Pre-Medications:</b>	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 _____	
<b>Supply Orders:</b> 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	<b>Induction:</b> 300mg IV infusion via gravity ---OR--- pump over 30 minutes at week 0, 2, and 6 <b>Maintenance:</b> 300mg IV infusion via gravity ---OR--- pump over 30 minutes every _____ weeks		NONE _____
INFLIXIMAB Avsola Inflixtra Remicade Renflexis	<b>Induction:</b> _____ mg/kg or _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours at weeks 0, 2, and 6 <b>Maintenance:</b> _____ 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.		NONE _____
OMVOH	<b>Induction:</b> 300mg IV infusion via gravity ---OR--- pump over 30 minutes at week 0, 4, and 8 <b>Maintenance:</b> 200mg SC injection (given as two consecutive injections of 100 mg each) at Week 12, and every 4 weeks thereafter		NONE _____
SKYRIZI	<b>Induction:</b> 600mg IV infusion via gravity ---OR--- pump over one hour at week 0, 4, and 8 <b>Maintenance:</b> 360mg SC injection at Week 12, and every 8 weeks thereafter		NONE _____
STELARA	<b>Induction (Adult Dosing -Based on body weight of patient at time of dosing):</b> 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 <b>Maintenance:</b> 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 \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_  
 Dispense as Written

Prescriber's Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_  
 Substitution Permitted

