

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)	☐ TB lab results within last 12 months
☐ Recent office visit notes, history & physical, lab & pertinent procedure results	☐ HBV lab results within last 12 months (<i>Infliximabs only</i>)
☐ Current medication list & list of prior medications tried and failed (with dates)	☐ Liver enzymes lab results (<i>Skyrizi only</i>)
☐ Line access documentation/verification if applicable	☐ Bilirubin levels (<i>Skyrizi only</i>)
☐ Vaccine status (any vaccination) and documentation of any recent vaccinations	☐ 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 over 30 minutes at week 0, 2, and 6 ☐ Maintenance: 300mg IV infusion over 30 minutes every _____ weeks ---OR--- Prefilled Pen 108mg SC every 2 weeks starting at week 6	NONE
☐ INFlixIMAB ☐ AVSOLA ☐ INFLECTRA ☐ RENFLEXIS ☐ ZYMFENTRA	☐ Induction: _____ mg/kg or _____ mg IV infusion via ☐ gravity ---OR--- ☐ pump over at least 2 hours at weeks 0, 2, and 6 ☐ 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> ☐ Maintenance: 120 mg SC every 2 weeks starting at week _____. If Zymfentra, initiating SUBQ maintenance therapy after IV induction therapy: 120 mg every 2 weeks starting at week 10. Switching from IV maintenance therapy: 120 mg every 2 weeks starting in place of the next scheduled IV maintenance dose.	NONE
☐ OMVOH	☐ Induction (UC): 300mg IV infusion via ☐ gravity ---OR--- ☐ pump over 30 minutes at week 0, 4, and 8 ☐ Maintenance: 200mg SC injection, given as two consecutive injections of 100mg each at Week 12, and every 4 weeks thereafter ☐ Induction (Crohn's): 900mg IV infusion via ☐ gravity ---OR--- ☐ pump over 30 minutes at week 0, 4, and 8 ☐ Maintenance: 300mg SC injection, given as two consecutive injections of 100mg + 200mg (or 100mg x 3) at Week 12, and every 4 weeks thereafter	NONE
☐ SKYRIZI	☐ Induction (Crohn's): 600mg IV infusion via ☐ gravity ---OR--- ☐ pump over one hour at week 0, 4, and 8 ☐ Maintenance: ☐ 180mg or ☐ 360mg SC injection at Week 12, and every 8 weeks thereafter ☐ Induction (UC): 1200mg IV infusion via ☐ gravity ---OR--- ☐ pump over two hours at week 0, 4, and 8 ☐ Maintenance: ☐ 180mg or ☐ 360mg SC injection at Week 12, and every 8 weeks thereafter	NONE
☐ STELARA (Ustekinumab) ☐ SELARSDI (Ustekinumab) ☐ YESINTEK (Ustekinumab-kfre)* ☐ WEZLANA (Ustekinumab-aauub) ☐ STARJEMZA (Ustekinumab-hmny) ☐ OTULFI (Ustekinumab-aauz)* *Interchangeable biosimilar	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 ☐ Maintenance: 90mg SC injection _____ weeks after induction and every _____ weeks thereafter	NONE
☐ TREMFYA	☐ Induction (Crohn's AND UC): 400mg (as 2 consecutive 200mg injections) SC induction on weeks 0, 4, and 8 ☐ Maintenance: 100mg SC injection every 8 weeks beginning at week 16 ☐ Maintenance: 200mg SC injection every 4 weeks beginning at week 12	NONE
☐ OTHER		NONE

By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

Prescriber's Signature	Print Name	Date	Prescriber's Signature	Print Name	Date
Dispense as Written			Substitution Permitted		