Gastroenterology Referral Form

Date:

1.)Patient Information *(Please provide front and back copy of patient's prescription insurance card)*

Name:		Date of Birth:	Sex: M F · Height: · Weight: lbs
Address:	APT/STE:	City:	State: · Zip:
Phone Number:		Alt. Phone Number:	SS#:
Text Messages? Y N	**Ship to:** **Patient** **Provider**	E-Mail Address:	
Insurance Plan:	ID #:	Bin: · PCN:	RX Group:

2.)Provider Information

Office Name:		Provider Name:	
Address:	APT/STE:	City:	State: · Zip:
Phone Number:		Fax Number:	
NPI:	Tax ID:	Provider Type:	

3.)Clinical Information *(please fax all applicable office notes & labs)*

Previous Therapy	Tried & Failed Duration	Not Tolerated	Contraindication	Additional Clinical Information
☐Cimzia				**TB Test:** **Yes** **No**
☐Entocort				**Date:** **Result:**
☐Humira				**Comorbidities:**
☐Methotrexate				
☐Pentasa				**Allergies:**
☐Sulfasalazine				
☐				Loading dose taken of medication requested below?
☐				**Yes** **No** **Date:**

☐K50.0 Crohn's Disease of Small Intestine, Without Complications
☐K50.80 Crohn's Disease of Both Intestines, Without Complications
☐K51.50 Left-Sided Ulcerative Colitis, Without Complications
☐K51.90 Right-Sided Ulcerative Colitis, Without Complications
☐K50.10 Crohn's Disease of Small Intestine, Without Complications
☐K50.90 Crohn's Disease of Both Intestines, Without Complications
☐K51.80 Left-Sided Ulcerative Colitis, Without Complications
☐Other(s):

4.)Medications

Medication	Dose/Strength	Directions	Quantity	Refills
Anucort Suppositories	25mg C-27.5mg	Insert 1 suppository rectally every		
Budesonide Caps/Tabs	3mg EC Capsules 9mg ER Tablets	Take_______capsule(s)/tablet(s) by mouth_______times daily		
Cimzia	6x200mg/mL PFS Starter	Inject 2 syringes (400mg) SQ at weeks 0, 2, and 4	6x200mg PFS	0
	2x200mg/mL PFS	Inject 2 syringes (400mg) SQ once every 4 weeks	2x200mg PFS	
Dificid	200mg Tablets	Take 1 tablet by mouth BID for 10 days	20	
Humira **CITRATE-FREE**	3x80mg/0.8mL Pens 6x40mg/0.4mL: Pens PFS	**Starter:** Inject 160mg SQ on day 1 then 80mg SQ on day 15	4 Week Supply	0
	40mg/0.4mL Pens 40mg/0.4mL PFS	Inject 40mg SQ on day 29 then every other week thereafter	4 Week Supply	
Original Humira	6x40mg/0.8mL: Pens PFS	Inject 160mg SQ on day 1, then inject 80mg SQ on day 15	1 Kit (6x40mg pens)	0
	40mg/0.8mL Pens 40mg/0.8mL PFS	Inject 40mg SQ every other week for maintenance	4 Week Supply	
Simponi	100mg/mL Pens	**Loading Dose:** Inject 200mg SQ at week 0 then continue with maintenance	2 pens/PFS	0
	100mg/mL PFS	**Maintenance Dose**: Inject 100mg SQ at week 2 and every 4 weeks thereafter	1 Pen/PFS	
Stelara Maintenance	90mg/mL PFS Date of infusion dose:	Inject 1 syringe (90mg) SQ every 8 weeks	8 Week Supply	
Xeljanz	10mg Tabs	**Starting Dose:** Take 10mg by mouth BID for 8 weeks	60	1
	5mg Tabs 10mg Tabs	**Maintenance:** Take _______ mg by mouth BID	60	
Xifaxan	550mg Tablets	H.E. Dosing: Take 1 tablet by mouth BID	60	
		IBS-D Dosing: Take 1 tablet by mouth TID for 14 days	42	

5.)Provider's Signature

Substitution Permissible

Dispense As Written

20190129@1
01/29/2019 sj

With your signature, you are authorizing the pharmacy and its' representatives to act as agents in initiation and follow up of the prior authorization process.