

Gastroenterology Referral Form



Fax completed form to: _____

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
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NURSING & LAB ORDERS

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion.
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:	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 _____
Pre-Medications:	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 _____	

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
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Is this a first dose?	Yes No	If No, when was last dose given? _____	When is patient due for next dose? _____
CIMZIA®	200x2 Prefilled Syringe 200x2 LYO Powder	Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 Inject 400mg subcutaneously once every 4 weeks	1 Kit 4 week supply
ENTYVIO	Induction: 300mg IV infusion over 30 minutes at week 0, 2, and 6 Maintenance: 300mg IV infusion over 30 minutes every _____ weeks		NONE
HUMIRA® Citrate Free	Crohn's/UC Starter Package (8mg - 80mg Pens) 40mg Pen 40mg PFS	Inject 160mg given as Two 80mg SubQ Day 1 --OR-- One 80mg SubQ Days 1 & 2, then Week 2 inject 80 mg subcutaneously on Day 15 Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply
INFLIXIMAB Avsola Inflectra Remicade Renflexis	Induction: _____ mg/kg or _____ mg IV infusion over at least 2 hours at weeks 0, 2, and 6 Maintenance: _____ mg/kg _____ mg IV infusion over at least 2 hours every _____ weeks (Note: Round to nearest 100mg for Medicaid patients) If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert.		NONE
SKYRIZI	Induction: 600mg IV infusion over one hour at week 0, 4, and 8 Maintenance: 360mg SC injection at Week 12, and every 8 weeks thereafter		NONE
STELARA	Induction (Adult Dosing -Based on body weight of patient at time of dosing): For patients 55kg or less administer 260mg IV infusion over at least 1 hour x 1 dose For patients more than 55kg to 85kg administer 390mg IV infusion over at least 1 hour x 1 dose For patients more than 85kg administer 520mg IV infusion over at least 1 hour x 1 dose Maintenance: 90mg SubQ injection _____ weeks after induction and every _____ weeks thereafter		NONE
OTHER			NONE

By signing this form and utilizing our services, you are authorizing EventusRx to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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