# Gastroenterology Referral Form

Please fax to

866.279.3315

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|---|---|
| Patient Name: | Primary Ins: |
| DOB: | BinRx/PCN#: |
| SSN: | ID#: |
| Address: | Group#: |
| City/ST/Zip: | Phone#: |
| Phone#: | Secondary Ins: |
| Emergency contact# | Sex: M F |
| Diagnosis: | Height: Weight: |
| ICD-10: | Allergies: |
| TB/PPD: ____Positive ____Negative Date: | HBV: ____Positive ____Negative Date: |

Previous treatment with: ____Sulfasalazine ____Corticosteroid ____Methotrexate ____5-ASA ____6-MP ___NSAIDS ____Azathioprine ____Remicade ____Other Biologics

Dates of Therapy:_____ Reason for Discontinuation:_____

| | | |
|---|---|---|
| **HUMIRA** | | |
| ❒ Starter Kit | ❒ Inject 4 pens - 4x40mg on Day 1, then 2 pens-2x40mg on Day 15 | 1 QTY 0 REFILLS |
| ❒ 40mg PEN<br>❒ 40mg PFS | ❒ Inject 40mg subq every OTHER week<br>❒ Inject 40mg subq ONCE a week | _____QTY _____REFILLS |
| **CIMZIA** | | |
| ❒ Starter Kit | ❒ Inject 400mg (2 PFS/Vials) subq at weeks 0, 2, and 4 | _____QTY _____REFILLS |
| ❒ 200mg PFS<br>❒ 200mg Lyo Powder Vial | ❒ Inject 200 mg (1 PFS/Vials) subq every other week<br>❒ Inject 400 mg (2 PFS/Vials) subq every 4 weeks | _____QTY _____REFILLS |
| **SIMPONI** | | |
| ❒ 100mg Smartject<br>❒ 100mg PFS | **Initial Dose**:<br>❒ Inject 200 mg subq at week 0, 100mg at week 2 and 100mg every 4 weeks after | _____QTY 0 REFILLS |
| | **Maintenance Dose:**<br>❒ Inject 100mg subq every 4 weeks | _____QTY _____REFILLS |
| **XIFAXAN** | | |
| ❒ 200mg tablet<br>❒ 550mg tablet | ❒ One tablet twice daily<br>❒ One tablet three times daily<br>❒ _____ | _____QTY _____REFILLS |
| **STELARA** | | |
| ❒ 130mg/26 mL | **Initial Dose**:<br>Induction: IV:<br>❒ ≤55 kg: 260 mg as single dose<br>❒ >55 kg to 85 kg: 390 mg as single dose<br>❒ >85 kg: 520 mg as single dose | _____QTY |
| ❒ 90mg/1ml PFS | **Maintenance Dose:**<br>❒ Inject 90 mg subq every 8 weeks; begin 8 weeks after the IV dose. | _____QTY _____REFILLS |
| **OTHER** | | |
| ❒ _____ | | _____QTY _____REFILLS |
| **OTHER** | | |
| ❒ _____ | | _____QTY _____REFILLS |

**Deliver to:** ___Patient's home ___MD's Office ___First dose to MD

**Training:** ___Abbott ___Cimplicity ___Physician in office

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

**Physician's Signature DAW** **Substitution Allowed** **Date**

| | | |
|---|---|---|
| Physician Name: | Office Contact: | |
| Address: | Phone: | email: |
| Address: | Fax: | |
| City/St/Zip: | NPI: | DEA: |