



# Gastroenterology Referral Form

Please fax to  
**866.279.3315**

402 Wilkins Wise Road, Ste. 38  
Columbus, MS 39705  
p 866.279.3314

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: _____			
<b>HUMIRA</b>			
<input type="checkbox"/> Starter Kit	<input type="checkbox"/> Inject 4 pens - 4x40mg on Day 1, then 2 pens-2x40mg on Day 15	___ 1 ___ QTY ___ 0 ___ REFILLS	
<input type="checkbox"/> 40mg PEN <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 40mg subq every OTHER week <input type="checkbox"/> Inject 40mg subq ONCE a week	___ QTY ___ REFILLS	
<b>CIMZIA</b>			
<input type="checkbox"/> Starter Kit	<input type="checkbox"/> Inject 400mg (2 PFS/Vials) subq at weeks 0, 2, and 4	___ QTY ___ REFILLS	
<input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200mg Lyo Powder Vial	<input type="checkbox"/> Inject 200 mg (1 PFS/Vials) subq every other week <input type="checkbox"/> Inject 400 mg (2 PFS/Vials) subq every 4 weeks	___ QTY ___ REFILLS	
<b>SIMPONI</b>			
<input type="checkbox"/> 100mg Smartject <input type="checkbox"/> 100mg PFS	<b>Initial Dose:</b> <input type="checkbox"/> Inject 200 mg subq at week 0, 100mg at week 2 and 100mg every 4 weeks after	___ QTY ___ 0 ___ REFILLS	
	<b>Maintenance Dose:</b> <input type="checkbox"/> Inject 100mg subq every 4 weeks	___ QTY ___ REFILLS	
<b>XIFAXAN</b>			
<input type="checkbox"/> 200mg tablet <input type="checkbox"/> 550mg tablet	<input type="checkbox"/> One tablet twice daily <input type="checkbox"/> One tablet three times daily <input type="checkbox"/> _____	___ QTY ___ REFILLS	
<b>STELARA</b>			
<input type="checkbox"/> 130mg/26 mL  <input type="checkbox"/> 90mg/1ml PFS	<b>Initial Dose:</b> Induction: IV: <input type="checkbox"/> ≤55 kg: 260 mg as single dose <input type="checkbox"/> >55 kg to 85 kg: 390 mg as single dose <input type="checkbox"/> >85 kg: 520 mg as single dose	___ QTY	
	<b>Maintenance Dose:</b> <input type="checkbox"/> Inject 90 mg subq every 8 weeks; begin 8 weeks after the IV dose.	___ QTY ___ REFILLS	
<b>OTHER</b>			
<input type="checkbox"/> _____	_____		___ QTY ___ REFILLS
<b>OTHER</b>			
<input type="checkbox"/> _____	_____		___ QTY ___ REFILLS
<b>Deliver to:</b> ___ Patient's home ___ MD's Office ___ First dose to MD		<b>Training:</b> ___ Abbott ___ Cimplicity ___ Physician in office	

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

<b>Physician's Signature DAW</b>		<b>Substitution Allowed</b>		<b>Date</b>
Physician Name:		Office Contact:		
Address:		Phone:	email:	
Address:		Fax:		
City/St/Zip:		NPI:	DEA:	

\*\*\*IMPORTANT NOTICE: This fax is intended to be delivered to the name addressee. It contains material confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify sender immediately. Gastroenterology mpts-rev-882017