EntrustRx
Specialty Pharmacy With A Personal Touch

Gastroenterology Referral Form

Please fax to
855.273.3925

2001 Campbell Station Pkwy, Ste A5
Spring Hill, TN 37174
p 855.273.3924

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 ❒ 40mg PFS	❒ Inject 40mg subq every OTHER week ❒ 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 ❒ 200mg Lyo Powder Vial	❒ Inject 200 mg (1 PFS/Vials) subq every other week ❒ Inject 400 mg (2 PFS/Vials) subq every 4 weeks	_____QTY _____REFILLS
SIMPONI		
❒ 100mg Smartject ❒ 100mg PFS	**Initial Dose**: ❒ Inject 200 mg subq at week 0, 100mg at week 2 and 100mg every 4 weeks after	_____QTY 0 REFILLS
	Maintenance Dose: ❒ Inject 100mg subq every 4 weeks	_____QTY _____REFILLS
XIFAXAN		
❒ 200mg tablet ❒ 550mg tablet	❒ One tablet twice daily ❒ One tablet three times daily ❒ _____	_____QTY _____REFILLS
STELARA		
❒ 130mg/26 mL	**Initial Dose**: Induction: IV: ❒ ≤55 kg: 260 mg as single dose ❒ >55 kg to 85 kg: 390 mg as single dose ❒ >85 kg: 520 mg as single dose	_____QTY
❒ 90mg/1ml PFS	**Maintenance Dose:** ❒ 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: