GASTROENTEROLOGY INFUSION REFERRAL FORM

Pharmacy SOLUTIONS

PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT	
Primary Caregiver/Alt Contact Name (If applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title
Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax	Referral Contact Email	
Office Phone	Office Fax	
Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name / Specialty		
Prescriber State License #		DEA #
NPI #		Medicaid UPIN #

INSURANCE INFORMATION

Insurance Provider		Plan ID #
BIN#:	PCN#:	RX Group#:
Insured's Name		Relationship to Patient

Eligible for Medicare (check one)	☐ Yes ☐ No	If yes, list Medicare #
Prescription Card (check one)	☐ Yes ☐ No	If yes, list carrier

Please include a copy of the front and back of insurance card.

CLINICAL INFORMATION

Prescription Type	☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date
Sample/Starter Product Provided? ☐ Yes ☐ No	If yes, Provide Qty	Date Sample Provided
Allergies ☐ NKDA ☐ Drug Allergies (please list)		
Therapies Tried and Failed (please list medications)		
Concurrent Medications		

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	
ICD-10 Codes	☐ K50.90 Crohn's disease unspecified without complications ☐ K51.90 Ulcerative colitis, unspecified, without complications ☐ Other _____	

We accept Escribe and fax prescriptions.

P 877.794.9833 | **F** 855.370.0086

REV.0521

PRESCRIPTIONS

Patient Last Name	Patient First Name	DOB

PRESCRIPTION INFORMATION

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Entyvio (vedolizumab)	☐ IV	Starting Dose ☐ Infuse 300 mg IV at weeks 0, 2, 6 and then every 8 weeks therafter Maintenance Dose ☐ Infuse 300 mg IV every 8 weeks	☐ Reconstitute each vial of Entyvio with 4.8 mL of sterile water and dilute in 250 mL of NS or sterile Lactated Ringers. Infuse over 30 minutes	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Remicade (infliximab)	☐ IV	Starting Dose 100 mg vial ☐ None ☐ 5 mg/kg Pt weight___(kg) =____mg IV every 8 weeks Maintenance dose 100 mg vial ☐ 5 mg/kg Pt weight___(kg) =____mg IV every 8 weeks ☐ Other _____	☐ Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired does in NS 250 mL to be infused over a period NOT less than 2 hours. ☐ Additional directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Stelara (ustekinumab	☐ IV	Loading Dose ☐ Infuse 260 mg IV at week 0 (55kg or less) ☐ Infuse 390 mg IV at week 0 (85kg >55kg) ☐ Infuse 520 mg IV at wek 0 (>85 kg) Maintenance Dose ☐ Inject 90 mg subcutaneously every 8 weeks (start 8 weeks after infused loading dose)	Loading Dose Dilute the desired dose in 250 mL of NS. Infuse over a period of at least an hour	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Normal Saline ☐ D5W	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Herparin 10 units/mL ☐ Herparin 100 units/mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Diphenhydramine	☐ PO ☐ IV ☐ IM	☐ 25 mg ☐ 50 mg ☐ _____	☐ After infusion ☐ PRN Allergic Reaction: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 500 mg ☐ 650 mg ☐ 1 gm ☐ _____	☐ Pre-Med: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000, 0.3 mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	☐ 1 year ☐ _____
☐ Other:					
☐ Vascular Access Method	☐ peripheral ☐ central ☐ other: _____				

Total RXs ____

Lab Orders _____

Skilled nursing visits as needed to establish venous access administer medication and assess general status and response to therapy. Dispense 1 month of drug, flushes, needles, syringes, ancillary supplies and medical equipment necessary to establish access and administer medication. Prescription to include all necessary ancillary supplies (needle, syringes, etc). If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted support program.

_____ ____/____/____ _____

Patient Signature Date Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting.)

_____ ____/____/____

Prescriber Signature Date

_____ ____/____/____

Supervising Physician Signature (Dispense as Written) Date

**The information contained in this document will become a legal prescription. Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.