

Gastroenterology Referral Form



QUALITY SPECIALTY PHARMACY

Prescriber's Name: _____

DEA #: _____ NPI: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

Date: _____ Needs by Date: _____

Language: _____ Nursing Instruction Required

Ship to: Patient MD Office Other: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet.

Patient Name: _____ Date of Birth: ____/____/____ Gender: M F

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION: Please send recent clinical notes, current medications, labs, and tests to expedite the **Prior Authorization.**

Diagnosis: K50.00 Crohn's Disease K51.90 Ulcerative Colitis K21.00 gastro-esophageal reflux disease with esophagitis K21.90 gastro-esophageal reflux disease without esophagitis
 Other: _____
 Height: _____ Weight: _____ lbs TB/PPD Test given? Yes No Results: _____
 Patient Allergies: _____
 Prior Failed Medications: _____ Treatment-naive
 Duration and Reason for D/C: _____

Comments/ Notes:

PRESCRIPTION INFORMATION

Medication	Strength	Directions/SIG	Quantity	Refill
<input type="checkbox"/> Humira	40 mg/mL	Crohn's/UC Starter Pack: <input type="checkbox"/> Inject four 40 mg SC injections on Day 1, then inject two 40 mg SC injections on Day 15 or <input type="checkbox"/> Inject two 40 mg SC injections on Days 1 and 2, then inject two 40 mg SC injections on Day 15 Maintenance Dose: <input type="checkbox"/> Humira Pen or <input type="checkbox"/> Humira Prefilled Syringe Day 29 and after: Inject 40 mg SC every other week Other: _____	6 pens	0
<input type="checkbox"/> Humira Citrate Free	<input type="checkbox"/> 80 mg/0.8 ml	Crohn's/UC Starter Pack: <input type="checkbox"/> Inject two 80 mg SC injections on Day 1, then inject one 80 mg SC injection on Day 15 or <input type="checkbox"/> Inject one 80 mg SC injection on Days 1 and 2, then inject one 80 mg SC injection on Day 15 Maintenance Dose: <input type="checkbox"/> Humira Pen or <input type="checkbox"/> Humira Prefilled Syringe Day 29 and after: Inject 40 mg SC every other week Other: _____	3 pens	0
	<input type="checkbox"/> 40 mg/0.4 mL			
<input type="checkbox"/> Cimzia	6 x 200 mg/mL PFS Starter Kit	Starter Pack: <input type="checkbox"/> Inject 400 mg SC (2 injections of 200 mg) initially week 0, repeat at week 2 & 4	1 kit (6 syringes)	0
	2 x 200 mg/mL PFS kit	Maintenance Dose: <input type="checkbox"/> Inject 400 mg (2 injections of 200 mg) SC every 4 weeks or Other: _____	___ kit(s)	
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100 mg/mL SmartJect PEN	Induction Dose: <input type="checkbox"/> Inject 200 mg SC at week 0, then 100 mg SC week 2	3	0
	<input type="checkbox"/> 100 mg/mL Prefilled Syringe	Maintenance Dose: <input type="checkbox"/> Inject 100 mg SC every 4 weeks or Other: _____		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130 mg / 26 ml vial	Induction Dose: <input type="checkbox"/> Infuse 260 mg (2 vials) as a single intravenous infusion	2 Vials	0
		<input type="checkbox"/> Infuse 390 mg (3 vials) as a single intravenous infusion	3 Vials	
		<input type="checkbox"/> Infuse 520 mg (4 vials) as a single intravenous infusion	4 Vials	
<input type="checkbox"/> 90 mg/ml PFS	Maintenance Dose: <input type="checkbox"/> Inject one 90 mg inj SC every 8 weeks, 8 weeks after initial IV dose			
<input type="checkbox"/> Uceris	9 mg tab	<input type="checkbox"/> 1 tablet QAM	30	
<input type="checkbox"/> Relistor	<input type="checkbox"/> 150 mg tablet	Three tablets daily in AM		
	<input type="checkbox"/> 8 mg/0.4 mL Prefilled Syringe	Inject 12 mg SC daily		
	<input type="checkbox"/> 12 mg/0.6 mL Prefilled Syringe			
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg	10 mg twice daily for at least 8 weeks; then 5 or 10 mg twice daily. Discontinue after 16 weeks of 10 mg twice daily, if adequate therapeutic benefit is not achieved.		
	<input type="checkbox"/> 10 mg			
<input type="checkbox"/> Xifaxan	<input type="checkbox"/> 200 mg <input type="checkbox"/> 550 mg Other: _____	TD <input type="checkbox"/> 1 200 mg tablet 3 times a day for 3 days		
		HE <input type="checkbox"/> 1 550 mg tablet 2 times a day		
		IBS-D <input type="checkbox"/> 1 550 mg tablet 3 times a day for 14 days		
Other:				

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Physician Signature: _____ Date: _____

*Prescription is VOID if the Number of drugs prescribed is NOT noted. _____ 1 2 3

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.