E-prescribe to Our Pharmacy "Quality RX" zip code 10453 in Bronx, NY

Gastroenterology Referral Form **Pharmacy Phone: 800-490-1755 Fax: 877-678-8786**

QUALITY SPECIALTY PHARMACY

Prescriber's Name: _____

DEA #: _____ NPI: _____

Address: _____

Date: _____ Needs by Date: _____

City, State, Zip: _____

Language: _____ ☐ Nursing Instruction Required

Phone: _____ Fax: _____

Ship to: ☐ Patient ☐ MD Office ☐ Other: _____

Office Contact: _____

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-naïve

Duration and Reason for D/C: _____

Comments/Notes:

PRESCRIPTION INFORMATION

Medication	Strength	Directions/SIG	Quantity	Refill
☐ **Humira**	40 mg/mL	**Crohn's/UC Starter Pack**: ☐ Inject four 40 mg SC injections on Day 1, then inject two 40 mg SC injections on Day 15 **or** ☐ Inject two 40 mg SC injections on Days 1 and 2, then inject two 40 mg SC injections on Day 15	6 pens	0
		☐ **Maintenance Dose**: ☐ Humira Pen or ☐ Humira Prefilled Syringe Day 29 and after: Inject 40 mg SC every other week		
		Other: _____		
☐ **Humira Citrate Free**	☐ 80 mg/0.8 ml	**Crohn's/UC Starter Pack**: ☐ Inject two 80 mg SC injections on Day 1, then inject one 80 mg SC injection on Day 15 **or** ☐ Inject one 80 mg SC injection on Days 1 and 2, then inject one 80 mg SC injection on Day 15	3 pens	0
	☐ 40 mg/0.4 mL	☐ **Maintenance Dose**: ☐ Humira Pen or ☐ Humira Prefilled Syringe Day 29 and after: Inject 40 mg SC every other week		
		Other: _____		
☐ **Cimzia**	6 x 200 mg/mL PFS Starter Kit	☐ **Starter Pack**: ☐ 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**: ☐ Inject 400 mg (2 injections of 200 mg) SC every 4 weeks **or**	___ kit(s)	
		☐ **Other**: _____		
☐ **Simponi**	☐ 100 mg/mL SmartJect PEN ☐ 100 mg/mL Prefilled Syringe	☐ **Induction Dose**: ☐ Inject 200 mg SC at week 0, then 100 mg SC week 2	3	0
		☐ **Maintenance Dose**: ☐ Inject 100 mg SC every 4 weeks **or**		
		☐ **Other**: _____		
☐ **Stelara**	☐ 130 mg / 26 ml vial	**Induction Dose**: ☐ Infuse 260 mg (2 vials) as a singe intravenous infusion	2 Vials	0
		☐ Infuse 390 mg (3 vials) as a singe intravenous infusion	3 Vials	
		☐ Infuse 520 mg (4 vials) as a singe intravenous infusion	4 Vials	
	☐ 90 mg/ml PFS	**Maintenance Dose**: ☐ Inject one 90 mg inj SC every 8 weeks, 8 weeks after intial IV dose		
☐ **Uceris**	9 mg tab	☐ 1 tablet QAM	30	
☐ **Relistor**	☐ 150 mg tablet	Three tablets daily in AM		
	☐ 8 mg/0.4 mL Prefilled Syringe	Inject 12 mg SC daily		
	☐ 12 mg/0.6 mL Prefilled Syringe			
☐ **Xeljanz**	☐ 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.		
	☐ 10 mg			
☐ **Xifaxan**	☐ 200 mg ☐ 550 mg Other: _____	TD: ☐ 1 200 mg tablet 3 times a day for 3 days		
		HE: ☐ 1 550 mg tablet 2 times a day		
		IBS-D: ☐ 1 550 mg tablet 3 times a day for 14 days		
Other:				

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Physician Signature: _____ Date: _____