

Gastroenterology Referral Form

Fax#: _____

Patient Information

Patient Name: _____ DOB: _____ SS#: _____ Ship To: Home Clinic

Please Attach a Demographics Page & Copy of Insurance Card with this Prescription if Available:

1. **Diagnosis:** K50.90 Crohn's Disease K51.90 Ulcerative Colitis Other: _____
2. **Drug Allergies:** _____
3. **Failed Medications:** NSAIDS _____ MTX _____ Biologics _____
(When) 6-MP _____ 5-ASA _____ Corticosteroids _____
 Sulfasalazine _____ Azathioprine _____ Other: _____
4. **Negative TB Skin Test (PPD Test):** Yes No When: _____ (Please Attach)

Self Injection Training

_____ At home by a home health nurse _____ At the physician's office

Medication

Remicade (infliximab)

Induction Dosage: _____ mg at weeks 0, 2, and 6

Maintenance Dosage: _____ mg every 8 weeks thereafter

Other Dosage: _____

Quantity 30 day supply

Refills: _____

Uceris 9mg

_____ 1 tablet PO once daily

_____ Other Sig: _____

Quantity: 28 day supply

Refills: _____

Cimzia

_____ Initial dose of 400 mg SC at weeks 0, 2, and 4 followed by:

_____ Maintenance dose of 400mg SC every 4 weeks

_____ Maintenance dose of 200 mg SC every 2 weeks

Quantity: 28 day supply

Refills: _____

Humira Crohn's Starter Pack (40mg / 0.8ml)

160mg SQ on Day 1(Week 0)

_____ Four 40mg SQ on day 1 - OR- _____ Two 40mg SQ on day 1 & 2

80mg SQ on Day 15 (Week 2)

Alternate Dosage: _____

Quantity: #1

Refills: None

Humira Crohn's Starter Pack – Citrate Free (40mg / 0.4ml)

160mg SQ on Day 1(Week 0)

_____ Two 80mg SQ on day 1 - OR- _____ One 80mg SQ on day 1 & 2

80mg SQ on Day 15 (Week 2)

Alternate Dosage: _____

Quantity: #1

Refills: None

Humira 40 mg (Maintenance) Citrate Free (40mg / 0.4ml) Regular (40mg / 0.8ml)

_____ Inject 40mg PEN SQ every other week starting day 29

-OR-

_____ Inject 40mg SYRINGE every other week starting day 29

Quantity: #2

Refills: _____

Simponi 100mg Pen Syringe

_____ Initial dosage: Inject 200 mg SQ at week 0, then 100 mg at week 2, followed by:

_____ Maintenance Dosage: Inject 100 mg SQ once every 4 weeks

Quantity: 28 day supply

Refills: _____

Xifaxan 550mg Tablet (for Hepatic Encephalopathy Only– K72.91)

_____ 550mg tablets taken orally twice a day

Quantity: 30 day supply

Refills: _____

Stelara

_____ Maintenance: Inject 90 mg SQ at week 8, then again every 8 weeks thereafter

Quantity: #1

Refills: _____

Xeljanz 5mg 10mg

_____ 1 tablet by mouth twice daily

Quantity: #60

Refills _____

Physician Prescription Orders

Physician Name: _____ NPI #: _____ Phone: _____ Fax: _____

Address: _____ Date: _____ Nurse: _____

Physician Signature: _____

Substitution permitted