Gastroenterology Referral Form
Fax#: _____

Patient Information

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

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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

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Medication

Remicade (infliximab)
Induction Dosage: _____ mg at weeks 0,2, and 6 **Quantity** 30 day supply **Refills:** _____
Maintenance Dosage: _____ mg every 8 weeks thereafter
Other Dosage: _____

Uceris 9mg **Quantity:** 28 day supply **Refills:** _____
____ 1 tablet PO once daily
_____ Other Sig: _____

Cimzia
____ Initial dose of 400 mg SC at weeks 0, 2, and 4 followed by:
_____ Maintenance dose of 400mg SC every 4 weeks **Quantity:** 28 day supply **Refills:** _____
_____ Maintenance dose of 200 mg SC every 2 weeks

Humira Crohn's Starter Pack (NDC # 0074-4339-06) **Quantity:** # 1 **Refills:** None
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: _____

Humira 40 mg / 0.8 ml (Maintenance) **Quantity:** # 2 **Refills:** _____
____ Inject 40mg **PEN** SQ every other week starting day 29 (NDC # 0074-4339-02)
-OR-
____ Inject 40mg **SYRING**E every other week starting day 29 (NDC # 0074-3799-02)

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:** _____

Physician Prescription Orders

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

Address: _____ Date: _____ Nurse: _____

Physician Signature: _____
Substitution permitted