ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

GASTROENTEROLOGY REFERRAL FORM

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐ Male ☐ Female	Weight:	☐ lbs ☐ kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

MEDICAL INFORMATION

(Check any that apply)

Diagnosis Date: _____ ICD-10: _____ Allergies: _____

**Date of last ☐ Orencia ☐ Remicade ☐ Humura ☐ Enbrel dose: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders_____

Hepatits B Protocol: Hep B antigen and Hep B Core AB total required. (Cimzia, Infliximab)

Hepatits B Labs: ☐ Hep B antigen attached ☐ Hep B Core antibody total attaced ☐ Draw Hep B Labs (Cimzia

TB Protocol: Baseline Testing: Quantiferon Gold (QFT Gold) or PPD (Cimzia, Infliximab, Stelara and Entyvio)

TB Test: ☐ Hep B antigen attached ☐ Hep B Core antibody total attaced

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Iron Deficiency Anemia ☐ Iron Deficiency Anemia with CKD not on dialysis **Required Recent Labs:** **CBC, Ferritin, Iron Studies**	☐ **Venofer** 200mg IV q 3 weeks x 5 doses ☐ **Venofer** 100mg IV q week x 7 weeks then every other week x x7 weeks ☐ **Venofer** 200mg IV - Administer 5 doses over a 14 day period ☐ **Venofer** 200mg IV weekly x 5 weeks ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg if patient weighing less than 50kg (110lbs) ☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500 mg if patient weighing 50kg (110lbs) or greater	☐ _____ ☐ x 1 year
☐ Crohn's Disease ☐ Ulcerative Colitis	☐ **Cimzia** 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks ☐ **Cimzia** _____mg Sub-Q every _____ weeks ☐ **Infliximab** Brand's available : ☐ Inflectra ☐ Remicade ☐ Renflexis **Dose:** _____mg/kg **Frequency** ☐ Every _____ weeks OR ☐ 0, 2, 6 then every 8 weeks Pre-medication Orders ☐ Tylenol 1000mg Antihistamine: ☐ Cetrizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO Additional Pre-Medication Orders ☐ Solu-Medrol 62.5mg IVP ☐ Solu-Medrol 125mg IVP ☐ Solu-Cortef _____mg IVP	☐ _____ ☐ x 1 year

INFUSION ORDERS (CONT.)

DIAGNOSIS	INFUSION ORDERS	REFILLS
Hypersensitivity/Anaphylaxis Response Protocol PRN	☐ **Stelara** initial infusion: ☐ <55kg 260mg IV over 1 hour x 1 dose ☐ 55kg to 85kg 390mg IV over 1 hour x 1 dose ☐ >85kg 520mg IV over 1 hour x 1 dose Pre-medication Orders ☐ Tylenol 1000mg ☐ Diphenhydramine 25mg ☐ Ondacetron 4mg IV PRN for nasuea ☐ Solu-Medrol 125mg + Cetirizine ☐ **Stelara** maintainance: ☐ 90mg SQ 8 weeks after initial and then every 8 weeks ☐ **Tysabri** 300mg every 4 weeks ☐ JCV antibody ☐ Patient TOUCH authorization ☐ **Entyvio** 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8weeks (baseline LFTs) ☐ **Entyvio** 300mg IV every 8 weeks Pre-medication Orders ☐ Diphenhydramine 25mg ☐ Acetaminophen 650mg PO ☐ Solu-Medrol _____mg IVP ☐ Solu-Cortef_____mg IVP	

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written) Date:_____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.