

# Gastroenterology

Referral Form



**DELIVERIT**<sup>TM</sup>  
Infusion & Specialty

Phone +1.832.939.8137

Fax: +1.832.939.8128

## Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Weight	_____lbs <input type="checkbox"/>	kg <input type="checkbox"/>
SSN		Phone		Allergies					
Address				City		State		Zip Code	

## Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

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

## Medical Information

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 \_\_\_\_\_

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

Hepatitis B Labs:  Hep B antigen attached  Hep B Core antibody total attached  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 attached

## Infusion Orders

Diagnosis	Infusion Orders	Refills
<input type="checkbox"/> Iron Deficiency Anemia	<input type="checkbox"/> <b>Venofer</b> 200mg IV q 3 weeks x 5 doses	<input type="checkbox"/> _____
	<input type="checkbox"/> <b>Venofer</b> 100mg IV q week x 7 weeks then every other week x 7 weeks	
	<input type="checkbox"/> <b>Venofer</b> 200mg IV - Administer 5 doses over a 14 day period	<input type="checkbox"/> x 1year
<input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis	<input type="checkbox"/> <b>Venofer</b> 200mg IV weekly x 5 weeks	
<b>Required Recent Labs:</b>	<input type="checkbox"/> <b>Injectafer</b> 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500 mg,if patient weighing less than 50kg (110lbs)	
<b>CBC, Ferritin, Iron Studies</b>	<input type="checkbox"/> <b>Injectafer</b> 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500 mg,if patient weighing 50kg (110lbs) or greater	

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## Infusion Orders

Diagnosis	Infusion Orders	Refills
<input type="checkbox"/> Crohn's Disease  <input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> <b>Cimzia</b> 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks <input type="checkbox"/> <b>Cimzia</b> _____ mg Sub-Q every _____ weeks <input type="checkbox"/> <b>Infliximab</b> Brand's available : <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis Dose: _____ mg/kg <b>Frequency</b> <input type="checkbox"/> Every _____ weeks OR <input type="checkbox"/> 0, 2, 6 then every 8 weeks Pre-medication Orders <input type="checkbox"/> Tylenol 1000mg Antihistamine: <input type="checkbox"/> Cetrizine 10mg PO Additional Pre-Medication Orders <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Solu-Medrol 62.5mg IVP <input type="checkbox"/> Solu-Medrol 125mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP	<input type="checkbox"/> _____  <input type="checkbox"/> x 1year
Hypersensitivity/Anaphylaxis Response Protocol PRN	<input type="checkbox"/> <b>Stelara</b> initial infusion: <input type="checkbox"/> <55kg 260mg IV over 1 hour x 1 dose <input type="checkbox"/> 55kg to 85kg 390mg IV over 1 hour x 1 dose <input type="checkbox"/> >85kg 520mg IV over 1 hour x 1 dose  Pre-medication Orders <input type="checkbox"/> Tylenol 1000mg <input type="checkbox"/> Diphenhydramine 25mg <input type="checkbox"/> Ondacetron 4mg IV PRN for nasuea <input type="checkbox"/> Solu-Medrol 125mg + Cetirizine  <input type="checkbox"/> <b>Stelara</b> maintainance: <input type="checkbox"/> 90mg SQ 8 weeks after initial and then every 8 weeks <input type="checkbox"/> <b>Tysabri</b> 300mg every 4 weeks <input type="checkbox"/> JCV antibody <input type="checkbox"/> Patient TOUCH authorization  <input type="checkbox"/> <b>Entyvio</b> 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8weeks (baseline LFTs) <input type="checkbox"/> <b>Entyvio</b> 300mg IV every 8 weeks  Pre-medication Orders <input type="checkbox"/> Diphenhydramine 25mg <input type="checkbox"/> Acetaminophen 650mg PO <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP	<input type="checkbox"/> _____  <input type="checkbox"/> x 1year

## Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address				City		State	Zip Code
<input type="checkbox"/> I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.						Date	
<input type="checkbox"/> DAW (Dispense as written).						Prescriber's Signature  X _____	
<small>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.</small>							