Gastroenterology

Referral Form

DELIVERIT™ 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 ☐ Female ☐	**Weight**	____lbs ☐ kg ☐
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 _____

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 attached

Infusion Orders

Diagnosis	Infusion Orders	Refills
☐ Iron Deficiency Anemia	☐ **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 1500 mg,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 1year
☐ Iron Deficiency Anemia with CKD not on dialysis **Required Recent Labs:** **CBC, Ferritin, Iron Studies**		

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Infusion Orders

Diagnosis	Infusion Orders	Refills
☐ 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 Additional Pre-Medication Orders ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Solu-Medrol 62.5mg IVP ☐ Solu-Medrol 125mg IVP ☐ Solu-Cortef _____ mg IVP	☐ _____ ☐ x 1year
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	☐ _____ ☐ x 1year

Prescriber Insurance Information

Prescriber Name		**NPI#**		**Office #**		**Fax #**	
Address		**City**		**State**		**Zip Code**	

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

☐ DAW (Dispense as written).

Date

Prescriber's Signature

X _____

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.