

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Email: \_\_\_\_\_

## Gastroenterology Referral Form

*Please attach copy of insurance cards (front and back)*

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	City: State: Zip:
Phone:	SSN:		Prescriber Name:

### Insurance Information

Insurance Plan:	Insurance Plan:	Prescriber NPI:
Policy #	Policy #	Nurse/Key Contact:
Plan I.D. #	Plan I.D. #	Phone: Fax:
		Email:

### Diagnosis and Clinical Information

*Please attach clinical/progress notes and test results supporting primary diagnosis*

<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Other: _____ _____ Currently received and/or prior failed therapies: _____ Length of treatment: _____ Reason for discontinuation: _____	<input type="checkbox"/> Lupus Erythematosus <input type="checkbox"/> Arthritic Psoriasis	TB/PPD Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date _____ Allergies: _____ _____ <input type="checkbox"/> NKDA Height: _____ Weight: _____ Treatment location: <input type="checkbox"/> Home <input type="checkbox"/> Infusion suite <input type="checkbox"/> Other: _____
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### Labs

Test	Frequency

### Nursing Orders

Skilled nurse to assess and administer and/or teach self-administration where appropriate. Nurse to provide ongoing support as needed x 1 year.

### Prescription Information

Medication	Dose/Strength	Directions	Refills
<input type="checkbox"/> Cimzia (certolizumab egol)	<input type="checkbox"/> 200mg vial (only)	<input type="checkbox"/> INITIAL: Infuse 400mg subcutaneously at week 0, 2 and 4 weeks thereafter	
<input type="checkbox"/> Entyvio (vedolizumab)	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> INITIAL: Infuse 300mg IV at week 0, 2, 6, then every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Infuse 300mg IV every _____ weeks	
<input type="checkbox"/> Omvoh	<input type="checkbox"/> 300mg/15mL <input type="checkbox"/> 100mg/mL prefilled syringe <input type="checkbox"/> 100mg/mL prefilled pen  <input type="checkbox"/> 200mg/mL prefilled syringe <small>(only for Crohn's disease, maintenance)</small> <input type="checkbox"/> 200mg/mL prefilled pen <small>(only for Crohn's disease, maintenance)</small>	For use with ulcerative colitis <input type="checkbox"/> INITIAL: Week 0, 4, 8: Infuse 300mg IV over at least 30 minutes <input type="checkbox"/> MAINTENANCE: Week 12 and every 4 weeks thereafter: Inject 200mg subcutaneously (given as two consecutive injections of 100 mg each)  For use with Crohn's disease <input type="checkbox"/> INITIAL: Week 0, 4, 8: Infuse 900mg IV over at least 90 minutes <input type="checkbox"/> MAINTENANCE: Week 12 and every 4 weeks thereafter: Inject 300mg subcutaneously (given as two consecutive injections of 100mg and 200mg, in any order)	

Continued on next page.

## Prescription Information, continued

Medication	Dose/Strength	Directions	Refills
<input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Brand name only <input type="checkbox"/> Substitution allowed <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis <input type="checkbox"/> Avsola	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> INITIAL: Infuse _____ mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Infuse _____ mg/kg IV every _____ weeks <input type="checkbox"/> Other _____ <input type="checkbox"/> Pharmacist will round to the nearest 100mg <input type="checkbox"/> Give exact dose (do NOT round)	
<input type="checkbox"/> Stelara (ustekinumab)	<input type="checkbox"/> 130mg / 26mL vial <input type="checkbox"/> 90mg (2x 45mg vials)	<input type="checkbox"/> INITIAL: Weight-based dosing, infuse IV (one time) <input type="checkbox"/> 55kg or less: 260mg (2 vials) <input type="checkbox"/> 55kg to 85kg 390mg (3 vials) <input type="checkbox"/> Greater than 85kg: 520mg (4 vials) <input type="checkbox"/> MAINTENANCE: Inject 90mg subcutaneously 8 weeks after initial dose, then every 8 weeks thereafter	
<input type="checkbox"/> Skyrizi (risankizumab)	<input type="checkbox"/> 600mg / 10mL vial Crohn's disease - infuse over 60 minutes <input type="checkbox"/> 1200mg (2x 600mg vials) Ulcerative colitis - infuse over 120 minutes <input type="checkbox"/> 180mg / 1.2mL <input type="checkbox"/> 360mg / 2.4mL	<input type="checkbox"/> INITIAL: Infuse 600mg IV at week 0, 4, and 8 <input type="checkbox"/> INITIAL: Infuse 1200mg IV at week 0, 4, and 8 <input type="checkbox"/> MAINTENANCE: Inject 180mg subcutaneously at week 12 and every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Inject 360mg subcutaneously at week 12 and every 8 weeks thereafter	
<input type="checkbox"/> Tremfya	<input type="checkbox"/> IV Starter Dose: 200mg <input type="checkbox"/> 100mg/mL One Press <input type="checkbox"/> 100mg/mL prefilled syringe <input type="checkbox"/> 200mg/2mL prefilled pen <input type="checkbox"/> 200mg/mL prefilled syringe	<input type="checkbox"/> INITIAL: 200mg IV at week 0, 4 and 8 (one-hour infusion) <input type="checkbox"/> INITIAL: 400mg subcutaneously at week 0, 4, and 8 (given as two consecutive injections of 200mg each) <input type="checkbox"/> MAINTENANCE: Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter	
<input type="checkbox"/> Other			

**Pre-Medication and Other Medications**

- \* Infusion supplies as per protocol
- \* Anaphylaxis kit as per protocol

- Acetaminophen \_\_\_\_\_ mg PO prior to infusion
- Diphenhydramine  
 \_\_\_\_\_ mg PO or     \_\_\_\_\_ mL IV prior to infusion
- 0.9% NaCl for hydration  
 \_\_\_\_\_ mL IV     before     after medication
- Other \_\_\_\_\_

**Flush Protocol**

- NaCl 0.9% 10mL
- Before and after infusion

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED**

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

This is not a valid prescription in the state of Arizona.