PHARMACY SPECIALIST
Your Partner in HealthCare

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Gastrointestinal Referral Form

DATE:_____**NEEDS BY DATE:** _____ **SHIP TO:**_____**PATIENT**_____**OFFICE**_____**OTHER** _____

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Social Security #: _____

Date of Birth: _____ Sex:_____M_____F

PRESCRIBER INFORMATION

Prescriber Name _____

DEA #:_____NPI#: _____

Group: _____

Address: _____

City, State, Zip: _____

Phone: (____)_____ Fax: (____)_____

INSURANCE INFORMATION: (please copy and attach the front and back of insurance and prescription drug card)

Medical History

Drug Allergies _____

- **Has the Patient been treated previously for this condition? Yes No**_____

NSAIDS_____ **Duration**_____ **Sulfasalazine**_____ **Duration**_____
Corticosteroid_____**Duration**_____ **5-AS A(5-** **Duration**_____
MTX_____ **Duration**_____ **Aminosalicylates)**_____ **Duration**_____
6-MP(6-mercaptopurine)_____
Azathioprine_____ **Duration**_____ **Biologics** _____ **Duration**_____
Other_____ **Duration**_____

- **Is patient currently on any therapy? __yes no List Meds**_____
- **Will patient stop taking Meds before starting the new med? Yes No if yes**
- **How long will the patient wait before starting the new med?**_____
- **Other meds patient is on**_____
- **Has patient received PPD(skin test)?Yes No_ Results**_____

Diagnosis _____**555.0 Crohn's Disease**_____**556.9 Ulcerative Colitis**_____**Other**

PRESCRIPTION INFORMATION

____**Cimzia**_____**Prefilled Syringe** _____**LYO Powder**
Starter dose: Inject 400mg SQ at Weeks 0, 2 and 4 QTY: 28 day supply Refill 0
Maintenance: Inject 400mg SQ once every 4 weeks QTY: 28 day supply Refills _____

____**Humira Pen Crohn's Disease Starter Pack** 40mg/0.8 ml
Starter dose: Week 0 (Day 1): 160mg SQ_____Four 40 mg SQ injections on day 1 **OR**____Two 40 mg SQ injections on days 1 & 2
Week 2(day 15) 80 mg (Two 40 mg injections) SQ on day 15
Alternate Dose:_____ Refills 0

____**Humira Maintenance Therapy:**_____**Humira Pen** 40 mg/0.8 ml _____**Humira Pre-filled Syringe** 40 mg/0.8 ml
____Maintenance dose (week 4+): 40 mg SQ every other week QTY: 2 Refills_____
____Alt. Dosage:_____ QTY:28 day supply Refills_____

____**Remicade 100mg vial** New Start:_____mg IV on: week 0, week 2, week 6, then
Maintenance Dose:_____mg IV every____weeks for_____infusions

____**Simponi UC 100mg** ____New Start: 200mg SQ at week 0, then 100mg at week 2, then 100mg every 4 weeks QTY: 3
____Maintenance Dose: Inject 100mg SQ once every 4 weeks QTY: 1 Refills_____

____**Epipen 0.3 mg** Inject 1 pen IM once, may repeat if necessary. Call 911 if needed. QTY: 2

____**Other** **Injection Training** **Please set up Nurse training for patient with the manufacturer if available**

By signing this form and utilizing our services, you are authorizing Pharmacy Specialists and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature **Date**