

Need a referral status update, Please provide your email:

***Patient Insurance and ID (front and back) are needed**

GASTROENTEROLOGY

New Prescription/Referral
Prescription Refill

of Refills:

Rx:

Patient Name:

Patient Weight:
kg

DOB:

ENTYVIO (vedolizumab):

300mg IV infusion for 30 mins at week 0, 2, & 6 then Q8weeks thereafter
300mg IV Infusion for 30 mins every 8 weeks

STELARA (ustekinumab):

Wt: <56kg: 260mg IV infusion at week 0
Wt: 56 to 85kg: 390mg IV infusion at week 0
Wt: >85kg: 520mg IV infusion at week 0
Inject 90mg SQ every 8 weeks

(* TB Test Results within 12 months are REQUIRED for:
Entyvio, Stelara, Infliximab, Skyrizi, Omvoh, Tremfya, Tysabri)

INFLIXIMAB:

REMICADE

INFLECTRA

RENFLEXIS

AVSOLA

3 mg/kg IV infusion for > 2 hours at week 0, 2, & 6 then Q8weeks thereafter
5 mg/kg IV Infusion every 8 weeks
10 mg/kg Others:

SKYRIZI:

600 mg OR 1200 mg IV at week 0, 4 and 8 weeks
180 mg OR 360 mg SQ at week 12, and every 8 weeks thereafter

OMVOH:

300 mg IV infusion at 0, 4, & 8 then 200 mg SQ every 4 weeks
900 mg IV infusion at 0, 4, & 8 then 300 mg SQ every 4 weeks

TREMFYA:

200 mg IV at 0, 4 & 8 weeks then 200mg SQ every 4 OR 100mg SQ every 8 weeks

TYSABRI:

300 mg IV infusion for > 1 hour every 28 days

Pre-Medication:

Solumedrol 125mg IVP
Solu-Cortef 100mg IVP
Others:

Tylenol _____mg PO
650mg 975mg

Benadryl _____ mg
25mg IV
50mg PO

ANA Kit Protocol:

OK to use

Dx:

Ulcerative Colitis [K51.90]

Crohn's Disease [K50.90]

OTHERS (Dx + ICD Code 10):

Physician Signature

NPI#:

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Email:

Fax:

Other:

Office Mailing Address:

Please include
the following

Patient demographics & Insurance attached

Diagnosis (supporting)

History and Physical

Lab Results

Clinical progress notes

Medication List

TB & Other Test Results

TB Test Results within 12 months (Required for: Entyvio, Stelara, Infliximab, Skyrizi, Omvoh, Tremfya, Tysabri)

Hep B Surface Antigen Results (Required for: Infliximab)

Liver Function Tests & Bilirubin (Required for: Skyrizi, Omvoh)

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.