InfuCare Rx

Gastroenterology Referral Form

# of Pages Faxed:____________
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required:__________________ Ship To: ☐ Home ☐ Office ☐ Other:__________________

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Phone:
Cell Phone:	Fax:
Alternate Phone:	DEA #: ______ NPI #: ______
Date of Birth:	Contact Person:

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: __________________ ID: __________ Group: __________
Secondary Insurance: __________________ ID: __________ Group: __________
Prescription Card: __________ ID: __________ BIN: __________ PCN: __________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS/CLINICAL INFORMATION

☐ K50.00 Crohn's Disease
☐ K51.90 Ulcerative Colitis
☐ Other: __________________

Prior Medication Failed: __________________
Length of Treatment: __________________
Reason for Discontinuation: __________________

TB/PPD test: ☐ Positive ☐ Negative ☐ Date Read: __________
Patient Weight: ______ ☐ kg ☐ lbs Height: ______ ☐ cm ☐ in
Allergies: __________________
Lab Data: __________________

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SC at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	1 month supply	
☐ Entyvio®	☐ 300mg/ml vial	☐ Initial: Infuse 300mg over 30 minutes at weeks 0, 2 and 6 ☐ Maintenance: Infuse 300mg over 30 minutes every 8 weeks	1 month supply	
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SC once a week ☐ Inject 40mg SC every other week ☐ Inject 160mg SC day 1, 80mg day 15, then 40mg every other week (per Humira starter kit)	1 month supply	
☐ Remicade®	☐ 100mg vial	☐ Inject ______ mg at weeks 0, 2, and 6 ☐ Inject ______ mg every ______ weeks		
☐ Simponi®	☐ 100mg Pen			
☐ Stelara®	☐ 130mg/26ml vial ☐ 90mg PFS ☐ 250mL NaCl bag	☐ Up to 55kg, infuse 260mg (2 vials) as a single IV infusion ☐ Greater than 55kg to 85kg, infuse 390mg (3 vials) as a single IV infusion ☐ Greater than 85kg, infuse 520mg (4 vials) as a single IV infusion ☐ Inject 90mg SC every 8 weeks		
☐ Other:				

ADDITIONAL COMMENTS:

Prescriber Signature: __________________ **Date:** __________ **UPIN:** __________

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