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

Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Alternate Phone:_____
Date of Birth:_____

PRESCRIBER INFORMATION

Prescriber Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
DEA #:_____ NPI #:_____
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:**_____