BiologicTx GASTRO™

MEDICATIONS NAMES A – R

(Cimzia®, Entyvio®, Humira®, Remicade®)

GASTROENTEROLOGY REFERRAL FORM

P: 877-567-8087
F: 877-567-8089
BiologicTx Gastro Total Care Portal
Referral: 844-304-8378

PATIENT INFORMATION (Complete the following or include demographic sheet)

Name: | Phone #1: | ☐ Home ☐ Cell ☐ Work

Address: | Phone #2: | ☐ Home ☐ Cell ☐ Work

City: | State: | Zip: | Social Security Number:

Email: | Primary Language:

CLINICAL INFORMATION

Date of Birth: | Sex: ☐ Male ☐ Female | BSA: ____ m² | Weight: ____ ☐ lbs ☐ kg | Height: ____ ☐ inches ☐ cm

Patient Ethnicity: | Allergies: | ☐ No Known Allergies

ICD-10 Diagnosis Date:

ICD-10 Diagnosis

☐ K50 Regional Enteritis ☐ K50.1 Crohn's Large Intestine ☐ K50.90 Crohn's Unspecified ☐ K50.8 Crohn's Large & Small Intestine

☐ K51 Ulcerative Colitis ☐ K72.90 Hepatic Encephalopathy ☐ K58.0 Irritable Bowel Syndrome with Diarrhea (IBS-D)

☐ Other:

Has patient had a positive TB test? ☐ Yes ☐ No | If yes, date of last chest x-ray:

Previously Tried/Failed Medications *(including dosage and frequency)*	Date of Trial	Reason for Discontinuation

ENROLLMENT CHECKLIST (Please provide for all patients)

Insurance Cards | Last 2 Visit Notes | Most Recent Labs | Imaging (*If Available) | Current Medication List

PRESCRIPTION INFORMATION - Pharmacy to coordinate injection training/home health nurse visit as necessary ☐ Yes ☐ No *(Ancillary supplies and kits provided as needed for administration)*

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Cimzia®** (certolizumab pegol) ☐ **Enroll in Cimplicity**	☐ Cimzia Starter Kit ☐ 200mg/1mL Prefilled Syringe ☐ 200mg Vial	☐ **Crohn's Induction Dose:** Inject subcutaneously 400mg at weeks 0, 2, and 4 ☐ **Crohn's Maintenance Dose:** Inject subcutaneously 400mg every 4 weeks		
☐ **Entyvio®** (vedolizumab) ☐ **Enroll in Entyvio Connect**	300mg vial	☐ **Initiation Dose:** Infuse 300mg IV over 30 minutes at weeks 0, 2, and 6 ☐ **Maintenance Dose:** Infuse 300mg IV over 30 minutes every 8 weeks		
☐ **Humira®** (adalimumab) ☐ **Enroll in MyHumira**	☐ 40mg Pen ☐ 40mg Prefilled Syringe ☐ Crohn's Starter Kit	☐ **Induction & Maintenance:** Inject 160mg (4 injections) subcutaneously on day 1, then 80mg (2 injections) at week two (day 15), then 40mg (1 injection) every other week starting at week 4 (day 29) ☐ **Maintenance Only:** Starting at week 4 (day 29), inject 40mg (1 injection) subcutaneously every other week ☐ **Other:** _____		
☐ **Remicade®** (infliximab) ☐ **Enroll in CarePath**	100mg/20mL vial	☐ **Initiation Dose:** Infuse 5mg/kg IV over 2 hours at weeks 0, 2, and 6 ☐ **Maintenance Dose:** Infuse _____ mg/kg IV over 2 hours every 8 weeks		
☐				
☐				
☐				

THE REMAINING GI MEDICAITONS ARE LOCATED ON BIOLOGICTX GASTROENTEROLOGY REFERRAL FORM S TO Z

PRESCRIBER INFORMATION (NPI# and DEA# are mandatory and required)

Name: | Nurse/Key Contact:

Practice/Hospital Name:

Phone: | Fax:

Address: | City: | State: | Zip:

NPI#: | DEA#: | License #:

DELIVERY INFORMATION

Ship to: ☐ Patient ☐ MD Office ☐ Other

Needs By Date:

Other Delivery Location:

PHYSICIAN SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

X _____ Dipense As Written | Date: _____

X _____ Product Substitution Permitted | Date: _____

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature: | Date:

Effective Date: 7/21/12 Attachment #: RFM-001C Revised Date: 6/20/17
Approved by: VP of Clinical Operations, Karen B. Spano RPh.