BiologicTx GASTRO™

MEDICATIONS NAMES S - Z

(Simponi®, Stelara®, Trulance™, Xifaxan®)

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
☐ **Simponi®** (golimumab) ☐ **Enroll in SimponiOne**	☐ 100mg Smartject ☐ 100mg Pre-filled syringe	☐ **Ulcerative Colitis Induction Dose:** 200mg initially administered by subcutaneous injection at week 0, followed by 100mg at week 2, and then start maintenance at week 6 ☐ **Ulcerative Colitis Maintenance Dose:** 100mg administered by subcutaneous injection every 4 weeks starting at week 6		
☐ **Stelara®** (ustekinumab) ☐ **Enroll in CarePath**	☐ 90mg/mL Prefilled Syringe ☐ 130mg/26mL Vial	☐ **Initiation Dose:** Infuse _____mg as initial intravenous dose over 1 hour as directed by prescriber ☐ Inject 90mg subcutaneously starting 8 weeks after the initial IV induction dose ☐ Inject 90mg subcutaneously every 8 weeks		
☐ **Trulance™** (plecanatide)	3mg Tablets	Take 1 tablet by mouth once daily, with or without food		
☐ **Xifaxan®** (rifaximin)	550mg Tablets	☐ **Hepatic Encephalopathy:** Take 1 tablet by mouth twice daily ☐ **IBS-D:** Take 1 tablet by mouth three times daily for 14 days, may treat recurrence up to 2 times ☐ Take _____ tablets _____ times per day		
☐				
☐				
☐				

THE REMAINING GI MEDICAITONS ARE LOCATED ON BIOLOGICTX GASTROENTEROLOGY REFERRAL FORM A TO R

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:

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to BiologicTx or any of its subsidiaries using the contact information provided on this cover sheet.
Effective Date: 7/21/12 Attachment #: RFM-001C Revised Date: 6/20/17
Approved by: VP of Clinical Operations, Karen B. Spano RPh.