

# Gastroenterology Therapies

Please fax completed referral form to 281-295-4088

## PATIENT DEMOGRAPHIC INFORMATION

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

**Diagnosis:** (ICD 10 Code Required)

Crohn's Disease (K50.00-K50.919), ICD 10 \_\_\_\_\_

Ulcerative Colitis (K51.00-K51.919), ICD 10 \_\_\_\_\_

Other: \_\_\_\_\_

### Prior Failed Therapy:

Med Failed: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_

Med Failed: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_

Med Failed: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_

**Test Results:** Please attach copy for all items checked.

Negative TB test

Other: \_\_\_\_\_

**Please include copy of insurance card, most recent H&P or MD note, medication list, and lab results.**

## THERAPY ORDERED

MEDICATION	DOSE	DIRECTIONS/DURATION
Cimzia® (certolizumab pegol)	<b>INITIAL:</b> 400mg <b>MAINTENANCE:</b> <input type="checkbox"/> 400mg <input type="checkbox"/> 200mg	<input type="checkbox"/> <b>INITIAL:</b> Inject 400mg SUBQ at Weeks 0, 2, and 4 <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 400mg SUBQ every 4 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 200mg SUBQ every 2 weeks x 1 year
Entyvio® (vedolizumab)	300mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV at Weeks 0, 2, and 6 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 8 weeks x 1 year
Remicade® (infliximab)	<input type="checkbox"/> <b>5mg/kg:</b> _____mg <input type="checkbox"/> <b>10mg/kg:</b> _____mg <input type="checkbox"/> <b>Other:</b> _____mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV at Weeks 0, 2, and 6 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 8 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every ____ weeks x 1 year
Renflexis® (infliximab-abda)	<input type="checkbox"/> <b>5mg/kg:</b> _____mg <input type="checkbox"/> <b>10mg/kg:</b> _____mg <input type="checkbox"/> <b>Other:</b> _____mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV at Weeks 0, 2, and 6 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 8 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every ____ weeks x 1 year
Inflectra® (infliximab-dyyb)	<input type="checkbox"/> <b>5mg/kg:</b> _____mg <input type="checkbox"/> <b>10mg/kg:</b> _____mg <input type="checkbox"/> <b>Other:</b> _____mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV at Weeks 0, 2, and 6 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 8 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every ____ weeks x 1 year
Tysabri® (natalizumab)	300mg	<input type="checkbox"/> Infuse IV every 4 weeks x 1 year
OTHER:		
OTHER:		

Is patient currently receiving therapy above from another facility?  NO  YES If yes, Facility Name: \_\_\_\_\_

## REFERRING PHYSICIAN INFORMATION

Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_



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