TEL: (310) 671-2600
FAX: (310) 671-2601
TOLL FREE: (844) 671-2600
INFO@MEDRXINFUSION.COM
MEDRXINFUSION.COM

Date Medication Needed: ______________________________

Ship to: ☐ Patient ☐ Prescriber ☐ Other: __________________

☐ Self injection teaching needed ☐ Prescriber's office will teach

☐ Home Health nurse to infuse ☐ Prescriber's ofc. will infuse

Gastroenterology Referral Form

This referral form is provided in order to best serve our patients and prescribers. Patients may choose any pharmacy of their choice.

Complete patient demographics below or otherwise provide the information requested along with this referral form. Also needed: 1) Patient insurance information (front and back of card) 2) History and physical, chart notes, laboratory results and other diagnostic tests needed to support the use of this medication 3) patient's medication history related to their current diagnosis/problem.

Patient name: ______________________________ Date of birth: __________ height: ________ weight: ________

Address: ______________________________ Allergies/Intolerances: ______________________________

Phone number(s): ______________________________ ☐ No known allergies: ________ Date of TB screening: ______

Treatment Diagnosis/Problem(s): ______________________________ Failed Medication with reasons: ____________________

Prescriber name: ______________________________ Contact person: ______________________________

Office Address: ____

Phone number: ____________________ Fax number: ____________________ NPI number: ____________________

☐ Cimzia (certolizumab) 200 mg ☐ pfs ☐ vial subcutaneously, ☐ 400 mg weeks 0,2 and 4, then 400 mg q4wks
☐ Starter Kit (6 x 200 mg pfs) 4 weeks supply for ______ months

☐ Humira (adalimumab) 40 mg ☐ pfs ☐ pensubcutaneously every 2 weeks or_____ 4 weeks supply for _____ months

☐ Humira Ulcerative colitis/Crohn's starter pack for 160 mg on day one (or 80 mg day 1, day 2) then 80 mg in 2 weeks 4 weeks supply for _____ months

☐ Simponi (golimumab) 100 mg ☐ pfs, ☐ smartject subcutaneously 200mg wk 0, then 100 mg week 2, then 100 mg q 4 weeks
4 weeks supply for ______ months

☐ Entyvio (bedolizumab) 300 mg in NS 250 ml IV over 30 minutes **Loading dose** ☐ **weeks 0,2 and 6,** then every ______ weeks 4 weeks supply for ______ months

☐ Remicade (infliximab) ______ mg/kg in NS 250 ml IV over 2 hrs **Loading dose** ☐ **weeks 0,2 and 6,** then every ______ weeks

(diagnosis/condition and response dictate the dose and frequency 5 mg/kg up to 10mg/kg, every 8 weeks) 4 weeks supply for ______ months

Therapy is going to be administered ☐ physicians office ☐ infusion suite ☐ in patients home
Note: supplies and diluents for physician office and infusion suite use may need to be ordered separately.

☐ Home Health care nursing is needed to infuse medication at home, which may include reconstitution and dilution of the medication according the manufacturer's or pharmacists instructions, accessing a vein for infusion intravenously, maintaining the intravenous catheter per nursing and MedRx protocol, as well as assessing the patient's response and tolerance to therapy.

Med Rx will supply the following for in home infusions: Note: **First lifetime doses generally should not be given at home. Consult with the Pharmacist to discuss**. Medication requires that anaphylaxis kit (epinephrine, diphenhydramine) be on hand at home for these infusions per MedRx and nursing policy and procedure. Supplies to administer which may include an infusion pump, supplies to maintain venous access, including heparin 100 u/ml flush and sodium chloride 0.9% flush.

☐ Patient has an existing intravenous access device (catheter type) _______________ date placed _______________ and will require Home Health to maintain the intravenous catheter and MedRx to provide supplies needed

Dispense supplies necessary for administration and hazardous waste disposal.

Physicians Signature:____ Date: ______________________________

IMPORTANT NOTICE: This form my contain confidential and privileged information and is only intended only for the person named herein. If you are not the named addressee, do not disseminate, distribute or copy this form or any of its contents. Please notify the sender immediately if you have received this document by mistake, then destroy this form.