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MedRX Infusion
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Gastroenterology Referral Form

Administer At: ☐ Patien's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name:_____

First Name:_____

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

2. Prescriber Information

Prescriber Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

NPI# _____ Office Contact:_____

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:_____ Height:_____ Weight:_____

Tried/Failed Meds and Therapies: _____ Negative TB test date:_____

Diagnosis (ICD 10 Code):_____

4. Prescription Information ☐ DAW1- Dispense as written. Do not substitute for generic

Medication	Dose	Directions	Dispense	Refill
☐ **Cimzia**	☐ 200 mg Starter Kit (6X200MG PFS) ☐ 200 mg PFS Kit (2X200MG PFS) ☐ 200 mg Vial Kit (2x 200mg vials)	☐ Initial dose: Inject 400 mg SC once weekly at weeks 0, 2, & 4		
		☐ Maintenance dose: Inject 400 mg SC Q4wks		
☐ **Entyvio**	☐ 300mg Reconstituted Vial	Infuse 300mg IV over 30 minutes at weeks 0, 2, and 6, then Q 8 weeks thereafter Other: _____	QS vials for___Infusions ☐ 1 year supply	
☐ **Humira Citrate-free**	Initial: Crohn's/UC Starter pk ☐ 3x 80mg/0.8ml pens	☐ Inject 160 mg SC on day 1, then inject 80 mg on day 15, then inject 40 mg Q2wks ☐ Inject 80 mg SC on day 1, 2, and 15, then inject 40 mg Q2wks		
☐ **Humira**	Maintenance: ☐ 2x 40mg Pens ☐ 2x 40mg Syringes	☐ Inject 40mg SC QOW Other: _____		
☐ **Infliximab** ☐ **Inflectra** ☐ **Remicade** ☐ **Avsola** ☐ **Renflexis** Pharmacy will substitute to biosimilar as preferred by patient's insurance unless marked as DAW above.	☐ IV therapy_____ mg/kg Or ☐ Total _____ mg	☐ Initial: Infuse via IV at 0, 2, and 6 weeks, followed by every 8 weeks thereafter ☐ Maintenance: Infuse via IV every 8 weeks ☐ Other: _____ Premedications: _____	QS vials for___Infusions ☐ 1 year supply	
☐ **Simponi**	☐ 100mg/ml PF syringe ☐ 100mg/ml PF Pen	☐ Induction: Inject 200 mg SC at week 0, then 100 mg at week 2, followed by ☐ Maintenance therapy of 100 mg SC every 4 weeks. Other: _____	☐ 1 month supply ☐ 3 month supply	
☐ **Skyrizi**	☐ Initial dose: Skyrizi 600mg/10ml Vial	☐ Induction dose: Skyrizi 600mg (diluted with Dextrose 5% W) Infuse: 600 mg at weeks 0, 4, and 8	3 total infusions 3 total vials	
	Maintenance SQ injector: ☐ Skyziri OBI 180mg/1.2ML ☐ Skyziri OBI 360mg/2.4ML	☐ SUBQ: Prefilled On-Body Injector: inject contents of 1 cartridge at week 12 and every 8 weeks thereafter		
☐ **Stelara**	Initial Dose ☐ 130mg/25ml SDV	☐ ≤55kg: Infuse 260 mg (2 vials) IV over at least 1 hour ☐ >55kg to 85kg: Infuse 390 mg (3 vials) IV over at least 1 hour ☐ >85kg: Infuse 520 mg (4 vials) IV over at least 1 hour	Dispense QS for initial infusion	
	Maintenance Dose ☐ 90mg/ml PFS	Maintenance Dose: Inject 90 mg SC 8 weeks after initial IV dose, then Q8wks therafter		
☐ **Other**				

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____