ivira specialty pharmacy

Gastroenterology Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME: _____
DATE OF REFERRAL: _____
SOCIAL SECURITY NUMBER: _____
DATE OF BIRTH: _____
PREFERRED CONTACT #: _____
SECONDARY CONTACT #: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

- ☐ K50.0 - Crohn's Disease of the small intestine
- ☐ K50.1 - Crohn's Disease of the large intestine
- ☐ K50.8 - Crohn's Disease of small & large intestine
- ☐ K50.9 - Crohn's disease, unscpeified
- ☐ Other ICD-10 code & description: _____
- ☐ K51.0 - Ulcerative pancolitis
- ☐ K51.2 - Ulcerative (chronic) proctitis
- ☐ K51.3 - Ulcerative (chronic) rectosigmoiditis
- ☐ K51.5 - Left sided colitis
- ☐ K51.8 - Other ulcerative colitis

PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

PRIOR THERAPY (if any):	APPROX START DATE:	APPROX. END DATE:	REASON FOR DISCONTINUATION:

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA

HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg

GENDER: ☐ F ☐ M

PATIENT CONSENT & AUTHORIZATION:

I hereby authorize Ivira to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

▶▶▶▶▶▶▶▶ _____
PATIENT SIGNATURE:

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

- ☐ 1. INSURANCE CARD (Front & Back)
- ☐ 2. PATIENT DEMOGRAPHICS
- ☐ 3. MOST RECENT LABS
- ☐ 4. H & P
- ☐ 5. NEGATIVE TB TEST RESULTS
- ☐ 6. NEGATIVE HEPATITIS B TEST RESULTS

TESTING RESULTS: If prescribing, Cimzia, Humira, Remicade, Stelara

TB SCREENING DATE: _____
HEP B SCREENING DATE: _____

MEDICATION WASTE:

Authorized to round up to nearest vial size?
☐ YES ☐ NO

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

- ☐ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER GREENHILL INFUSION POLICY AND PROCEDURE
- ☐ OTHER: (please fax other reaction orders if checking this box)

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior every infusion	PRN
Acetaminophen ____ mg PO	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Diphenhydramine ____ mg PO	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Diphenhydramine ____ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 minutes.	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Methylprednisolone ____ mg IV push over 5 minutes.	☐	
Methylprednisolone 100mg IV	☐	

ivira specialty pharmacy

Gastroenterology Referral Form

MEDICATION SELECTION:

CIMZIA (certolizumab pegol)	**INDUCTION DOSE:** ☐ 400 MG SC on WEEKS 0, 2, & 4 **MAINTENANCE DOSE:** ☐ 400 MG SC EVERY 4 WEEKS REFILLS:_____
Entyvio vedolizumab	**INDUCTION DOSE:** ☐ 300 MG IV WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 300 MG IV EVERY 8 WEEKS **ALTERNATIVE DOSE:** ☐ _____ REFILLS:_____
HUMIRA adalimumab	**INDUCTION DOSE:** ☐ 160 MG SC then 80 MG SC TWO WEEKS LATER **MAINTENANCE DOSE:** ☐ 40 MG SC QOW, BEGINNING DAY 29 **ALTERNATIVE DOSE:** ☐ _____ REFILLS:_____
Inflectra infliximab	**INDUCTION DOSE:** ☐ 5 MG/KG IV on WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 5 MG/KG OR ☐ 10 MG/KG IV EVERY 8 WEEKS **ALTERNATIVE DOSE:** ☐ _____ MG/KG IV EVERY ____ WEEKS REFILLS:_____
Remicade INFLIXIMAB	**INDUCTION DOSE:** ☐ 5 MG/KG IV on WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 5 MG/KG OR ☐ 10 MG/KG IV EVERY 8 WEEKS **ALTERNATIVE DOSE:** ☐ _____ MG/KG IV EVERY ____ WEEKS REFILLS:_____
Simponi golimumab	**INDUCTION DOSE:** ☐ 200 MG SC, THEN 100MG SC AT WEEK 2 **MAINTENANCE DOSE:** ☐ 100 MG SC EVER 4 WEEKS REFILLS:_____
Simponi ARIA golimumab for infusion	☐ 2 MG/KG on WEEKS 0, 4, & EVERY 8 WEEKS THEREAFTER REFILLS:_____
Stelara (ustekinumab)	**LOADING DOSE:** ☐ 45 MG SC THEN 45 MG SC 4 WEEKS LATER or ☐ 90 MG SC THEN 90 MG SC 4 WEEKS LATER **MAINTENANCE DOSE:** ☐ 45 MG SC EVERY 12 WEEKS or ☐ 90 MG SC EVERY 12 WEEKS REFILLS:_____
XELJANZ (tofacitinib)	**IR:** ☐ 5 MG PO BID ☐ 10 MG PO BID x #60 **XR:** ☐ 22 MG PO DAILY ☐ 11 MG PO DAILY x #30 REFILLS:_____
IMMUNOGLOBULIN THERAPY	**BRAND:** ☐ NO PREFERENCE ☐ GAMUNEX ☐ OCTAGAM ☐ _____ **DOSING:** ☐ _____ GRAMS IV ☐ _____ GRAMS SC **DIRECTIONS:** _____ REFILLS:_____
RITUXIMAB	**BRAND:** ☐ NO PREFERENCE ☐ RITUXAN ☐ TRUXIMA ☐ MABTHERA ☐ _____ **MAINTENANCE DOSE:** ☐ 2000 MG IV EVERY 6 MONTHS THERAFTER REFILLS:_____

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: