GASTROENTEROLOGY INFUSION Referral Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Hy-Vee health

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Patient Information

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

Prescriber Information

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax	
Referral Contact Email	Office Phone	Office Fax	
Practice/Facility Name	Prescriber Name/Specialty		
Address	City	State	ZIP

**** Please include a copy of the front and back of insurance card. ****

Clinical Information – Please include applicable clinical chart notes.

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			Therapy Start Date	
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Therapies Tried and Failed (please list medications)				
Other/Concomitant Medications (please list)				
Allergies ☐ NKDA ☐ Drug Allergies (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				
ICD-10 Code ☐ K50.90 Crohn's disease, unspecified, without complications ☐ K51.90 Ulcerative colitis, unspecified, without complications		☐ Other _____		

Prescription Information – Please Escribe if required by state law.

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Entyvio (vedolizumab)	☐ IV	Starting Dose ☐ Infuse 300 mg IV at weeks 0, 2, 6 and then every 8 weeks therafter Maintenance Dose ☐ Infuse 300 mg IV every 8 weeks	☐ Reconstitute each vial of Entyvio with 4.8 mL of sterile water and dilute in 250 mL of NS or sterile Lactated Ringers. Infuse over 30 minutes.	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Remicade (infliximab)	☐ IV	Starting Dose 100 mg vial ☐ None ☐ 5 mg/kg Pt weight___(kg) =____mg IV every 8 weeks Maintenance dose 100 mg vial ☐ 5 mg/kg Pt weight___(kg) =____mg IV every 8 weeks ☐ Other _____	☐ Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired does in NS 250 mL to be infused over a period NOT less than 2 hours. ☐ Additional directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Stelara (ustekinumab)	☐ IV	Loading Dose ☐ Infuse 260 mg IV at week 0 (55kg or less) ☐ Infuse 390 mg IV at week 0 (85kg >55kg) ☐ Infuse 520 mg IV at wek 0 (>85 kg) Maintenance Dose ☐ Inject 90 mg subcutaneously every 8 weeks (start 8 weeks after infused loading dose)	Loading Dose Dilute the desired dose in 250 mL of NS. Infuse over a period of at least an hour.	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Vascular Access Method ☐ Peripheral ☐ Central ☐ Other: _____					
☐ Normal Saline ☐ D5W	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Diphenhydramine	☐ PO ☐ IV ☐ IM	☐ 25 mg ☐ 50 mg ☐ _____	☐ After infusion ☐ PRN Allergic Reaction: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 650 mg ☐ _____ ☐ 500 mg ☐ 1 gm	☐ Pre-Med: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	NPI #	Date
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)		

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific pharmacy and medical board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information, which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.

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Prescriber Information

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

**** Please include a copy of the front and back of insurance card. ****

Clinical Information – Please include applicable clinical chart notes.

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			Therapy Start Date	
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Allergies ☐ NKDA ☐ Drug Allergies (please list)				
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ICD-10 Code	☐ K50.90 Crohn's disease, unspecified, without complications ☐ K51.90 Ulcerative colitis, unspecified, without complications	☐ Other _____		

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MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000, 0.3 mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	☐ 1 year ☐ _____
☐ Other:	☐ _____				

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ NPI # _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

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Prescriptions

Hy-Vee health

Patient Last Name	Patient First Name	DOB

Prescription Information

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Entyvio (vedolizumab)	☐ IV	Starting Dose ☐ Infuse 300 mg IV at weeks 0, 2, 6 and then every 8 weeks therafter Maintenance Dose ☐ Infuse 300 mg IV every 8 weeks	☐ Reconstitute each vial of Entyvio with 4.8 mL of sterile water and dilute in 250 mL of NS or sterile Lactated Ringers. Infuse over 30 minutes.	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Remicade (infliximab)	☐ IV	Starting Dose 100 mg vial ☐ None ☐ 5 mg/kg Pt weight___(kg) =____mg IV every 8 weeks Maintenance dose 100 mg vial ☐ 5 mg/kg Pt weight___(kg) =____mg IV every 8 weeks ☐ Other _____	☐ Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired does in NS 250 mL to be infused over a period NOT less than 2 hours. ☐ Additional directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.). _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Stelara (ustekinumab	☐ IV	Loading Dose ☐ Infuse 260 mg IV at week 0 (55kg or less) ☐ Infuse 390 mg IV at week 0 (85kg >55kg) ☐ Infuse 520 mg IV at wek 0 (>85 kg) Maintenance Dose ☐ Inject 90 mg subcutaneously every 8 weeks (start 8 weeks after infused loading dose)	Loading Dose Dilute the desired dose in 250 mL of NS. Infuse over a period of at least an hour.	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Normal Saline ☐ D5W	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Herparin 10 units/mL ☐ Herparin 100 units/mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Diphenhydramine	☐ PO ☐ IV ☐ IM	☐ 25 mg ☐ 50 mg ☐ _____	☐ After infusion ☐ PRN Allergic Reaction: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 650 mg ☐ _____ ☐ 500 mg ☐ 1 gm	☐ Pre-Med: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000, 0.3 mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	☐ 1 year ☐ _____
☐ Other:					
☐ Vascular Access Method	☐ Peripheral ☐ Central ☐ Other: _____				

Total RXs _____

Lab Orders _____

Skilled nursing visits as needed to establish venous access administer medication and assess general status and response to therapy. Dispense 1 month of drug, flushes, needles, syringes, ancillary supplies and medical equipment necessary to establish access and administer medication. Prescription to include all necessary ancillary supplies (needle, syringes, etc.). If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted support program.

_____ ____/____/____ _____

Patient Signature **Date** **Account Manager**

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

_____ ____/____/____

Prescriber Signature **Date**

_____ ____/____/____

Supervising Physician Signature (Dispense as Written) **Date**

The information contained in this document will become a legal prescription.* ***Follow all state medical board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. *If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.*