CURBSIDE INFUSION SERVICES

# Gastroenterology Referral Form

# of Pages Faxed: _____
Fax Referral To: 877-428--1627
Phone: 877-428-7248

Date Required: _____ Ship To: ☐ Patient ■ MD Office ☐ Other: _____

## PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ ■ Male ☐ Female
Emergency Contact: _____ Phone: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

## INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

## To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

### PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ K50.00 Crohn's Disease
☐ K51.90 Ulcerative Colitis
☐ Other: _____

Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

TB/PPD test: ☐ Positive ☐ Negative ☐ Date Read: _____
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ■ No
Site of Care: ☐ Home ■ MD Office ☐ Other: _____

## PRESCRIPTION INFORMATION

| Medication: | Dose/Strength: | Directions: | Refills: |
|---|---|---|---|
| ☐ Cimzia® | ☐ 200 mg prefilled syringe<br>☐ 200 mg vial | ☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6)<br>☐ **MAINTENANCE:** Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2) | |
| ☐ Entyvio® | ☐ 300 mg vial | ☐ **INITIAL:** Infuse 300 mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3)<br>☐ **MAINTENANCE:** Infuse 300 mg IV over 30 minutes every _____ weeks (Quantity: 1) | |
| ☐ Humira®<br>☐ Humira® Citrate Free | ☐ Crohn's/UC Starter Package<br>☐ 40 mg Pen<br>☐ 40 mg prefilled syringe | ☐ **INITIAL:** Inject 160 mg (4 pens) SQ on day 1, then 80 mg (two pens) day 15, then maint. dose (1 pkg)<br>☐ **MAINTENANCE:** Inject 40 mg SQ (1pen) every other week (Quantity: 3)<br>☐ **MAINTENANCE:** Inject 40 mg SQ (1 prefilled syringe) every other week (Quantity: 3) | |
| ☐ Inflectra®<br>☐ Remicade®<br>☐ Renflexis™ | ☐ 100 mg vial | ☐ **INITIAL:** Infuse IV _____ mg/kg (Dose _____mg) at 0, 2, and 6 weeks (Quantity: _____)<br>☐ **MAINTENANCE:** Infuse IV _____ mg/kg (Dose _____ mg) every _____ weeks (Quantity: _____)<br>☐ Other: _____<br>☐ Pharmacist will round to the nearest 100<br>☐ Give exact dose (do NOT round) | |
| ☐ Simponi® | ☐ 100 mg SmartJect® Pen<br>☐ 100 mg prefilled syringe | ☐ **INITIAL:** Inject 200 mg SQ on day 0, then 100 mg on day 14 (Quantity: 3)<br>☐ **MAINTENANCE:** Inject 100 mg SQ every 4 weeks (Quantity: 1) | |
| ☐ Stelara® | ☐ 130 mg/26mL vials<br>☐ 90 mg (2x 45 mg vials) | ☐ **INITIAL:** Weight based dosing, infuse IV up to 55 kg = 260 mg (2 vials), > 55 kg to 85 kg = 390 mg (3 vials), > 85 kg = 520 mg (4 vials)<br>☐ **MAINTENANCE:** Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter | |
| ☐ Xeljanz® | ☐ 10 mg tablets<br>☐ _____ mg tablets | ☐ **INITIAL:** Take 10 mg PO twice daily (Quantity: 60 with 1 refill)<br>☐ **MAINTENANCE:** Take _____ mg PO twice daily (Quantity: 60) | |
| ☐ OMVOH or other | ☐ 300mg/15 ml<br>☐ other: _____ | ☐ **INITIAL:** administered by IV over at least 30 minutes at weeks 0, 4, and 8<br>☐ **MAINTENANCE:** 200mg administered by SQ, given as 2 consecutive injections of 100mg each at week 12 & every 4 weeks thereafter ☐ other: _____ | |

**Pre-Medications & Other Medications**
- Infusion supplies as per protocol
- Anaphylaxis Kit as per protocol

☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ☐ IV
☐ 250ml 0.9% NaCl for hydration
☐ Quzyttir 10mg IVSP over 1-2 minutes
☐ Other: _____

**Flush Protocol**
- NaCl 0.9% 10ml
- Before and after infusion

*By signing this form and using our services, you are authorizing Curbside Infusion to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.*

**Prescriber Signature:** _____ **Date:** _____