Your Health, True Wealth

Gastroenterology Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:
f: 818-882-8929

PATIENT INFORMATION

Patient Name	DOB	Contact Phone	
Address	City	State	Zip
Gender ☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐Allergies		
ICD-10 code (required)	ICD-10 description		
Patient Status ☐New to Therapy ☐Continuing Therapy	TB Skin Test ☐Yes ☐No	Hepatitis B Screen ☐Yes ☐No	

PRESCRIBER INFORMATION

Ordering Prescriber	Prescriber NPI		
Practice Name	Phone	Fax	
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

☐Insurance Cards	☐History & Physical	☐Most Recent Labs	☐Medication List

GASTROENTEROLOGY TREATMENT PLAN

☐ Remicade® Biosimilar_____
Loading dose: ☐5mg/kg ☐7.5mg/kg ☐10mg/kg at 0, 2 and 6 weeks, then every _____ weeks thereafter

☐ Entyvio®
☐ 300 mg infused IV at 0, 2, and 6 weeks, then every _____ weeks thereafter.

☐ Stelara® or Biosimilar _____
130 mg (5mg/ml) single dose vials for intravenous use :
☐(≤55kg) 260 mg IV over 1 hour x 1 dose
☐(55kg to 85 kg) 390 mg IV over 1 hour x 1 dose
☐(>85kg) 520 mg IV over 1 hour x 1 dose
☐ Maintenance: Inject 90mg - (2x - 45mg) SC 8 weeks after the initial IV infusion then every 8 weeks thereafter

☐ Skyrizi®
☐ Crohn's Loading Doses - Infuse 600 mg IV at weeks 0, 4 and 8
☐ Ulcerative Colitis Loading Doses - Infuse 1200 mg IV at weeks 0, 4 and 8
☐ Maintenance Dose - Inject 360 mg SC at week 12 and then every 8 weeks thereafter

☐ Tremfya®
☐ Crohn's Loading Doses - 400 mg SC at weeks 0, 4, 8
☐ Ulcerative Colitis and Crohn's Loading Doses-Infuse ☐ 200 mg IV ☐ 400mg SC at weeks 0, 4, 8
☐ Maintenance Doses-200 mg SC q 4 wks or 100 mg SC q 8 wks

☐ Other	Include dosage, frequency and any other special instructions.

☐ Refill for 1 year

NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

PREMEDICATION

☐ Include premedication per Northridge Pharmacy Specialty and Infusion's infusion protocol.
☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ Other

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____