aleracare
advanced specialty pharmacy

Gastroenterology
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Considerations

Diagnosis Code: ◯ E78.0 (Pure Hypercholesterolemia) ◯ E78.2 (Mixed hyperlipidemia) ◯ Other:_____

History: Has the Patient been treated previously for this condition? ◯ Yes ◯ No

◯ NSAIDS	Duration:	◯ Sulfasalazine	Duration:	◯ Corticosteroid	Duration:
◯ MTX	Duration:	◯ 5-ASA (5-Amino salicylates)	Duration:	◯ 6-MP (Mercaptopurine)	Duration:
◯ Biologics	Duration:	◯ Azathioprine	Duration:	◯ Other	Duration:

Is the patient currently on any therapy? ◯ Yes ◯ No List Meds: _____

Will patient stop taking meds before starting the new med? ◯ Yes ◯ No How long will the patient wait before starting the new med? _____

Has patient received PPD (skin test)? ◯ Yes ◯ No Results: _____

Medication	Dose/Strength	Directions for Use	Qty	Refills
◯ **CIMZIA®**	◯ 200x2 Prefilled Syringe ◯ 200x2 LYO Powder	◯ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 ◯ Inject 400mg subcutaneously once every 4 weeks	4 week supply	
◯ **ENTYVIO®**	◯ 300mg	◯ Induction dose 300mg IV weeks 0,2,6. Maintenance Dose 300mg Q8 Weeks	4 week supply	
◯ **HUMIRA®** ◯ **HUMIRA® CITRATE-FREE**	◯ Crohn's Starter Kit ◯ 40mg Pen ◯ 40mg Prefilled Syringe ◯ 80mg Pen	◯ Inject 160mg (two 80mg) SubQ day 1, **or** ◯ Two 40mg SubQ days 1 & 2, **then** ◯ Week 2 inject 80mg (one 80mg or two 40mg injections) subcutaneously on day 15, **then** ◯ Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	None
◯ **INFLIXIMAB®** (Inflectra) ◯ **REMICADE®**	◯ 100mg LYO Vial	◯ 5mg/kg IV at week 0, 2, and 6 weeks, then every 8 weeks	4 week supply	
◯ **SIMPONI®**	◯ 100mg SmartJect ◯ 100mg Prefilled Syringe	◯ Inject 200mg SubQ at week 0; then 100mg at week 2, 100mg every 4 weeks ◯ Inject 100mg subcutaneously once every 4 weeks	Loading Dose 4 week supply	None
◯ **STELARA®**	◯ 130mg/ml	◯ 260mg (if <56Kg), ◯ 390mg (if <86Kg) ◯ 560mg (if >85Kg) ◯ Maintenance Dose: infuse 90mg SQ every 8 weeks		
◯ **SYPRINE®**	◯ 250mg Capsules	◯ Take_____capsules by mouth_____times daily	4 week supply	
◯ **TYSABRI®**	◯ 300mg Vial	◯ Infuse _____mg IV every _____weeks for		
◯ **XIFAXAN®**	◯ 550mg Tablets	◯ 1 tablet by mouth twice daily	4 week supply	
◯ **OTHER**				

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature **Date**