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:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (ID & Group #) ◯ Current Medications ◯ History/Progress Notes

Labs Needed Prior to Initiation

◯ Tuberculosis ◯ Hepatitis B antigen and antibody ◯ CBC with diff ◯ CMP

Diagnosis

ICD-10 Codes: ◯ K50 Crohn's Disease ◯ K51.9 Ulcerative Colitis, unspecified ◯ K50 Irritable Bowel Syndome w/diarrhea

Other: _____

Medication	Dose	Directions for Use	Qty	Refills
◯ **CIMZIA®** (certolizumab pegol)	◯ 200 mg/mL x 2	◯ **Initial:** Inject 400 mg subq at weeks 0, 2, and 4 ◯ **Maintenance:** Inject 400 mg subq every 4 weeks		
◯ **ENTYVIO®** (vedolizumab) ◯ **ENTYVIO® Pen** (vedolizumab)	◯ 300 mg vial ◯ 108 mg/0.68 mL	◯ **Initial:** Infuse 300 mg IV at week 0, 2, and 6 **Maintenance:** ◯ Infuse 300 mg IV every 8 weeks ◯ Inject 108 mg subq every 2 weeks ◯ Other:_____		
◯ **HUMIRA®** **Crohn's/UC Starter Kit** (adalimumab) ◯ **HUMIRA®** (adalimumab) ◯ **PFS** ◯ **Pen** ◯ **Other biosimilar:** _____	◯ Starter kit ◯ 40 mg/0.4 mL ◯ 40 mg/0.8 mL ◯ 80 mg/0.8 mL	◯ **Initial:** Inject 160 mg subq over 1-2 days, 80 mg 2 weeks later on day 15 **Maintenance:** ◯ Inject 40 mg subq every other week beginning day 29 ◯ Other:_____	1 kit	
◯ **REMICADE®** (infliximab) ◯ **Other biosimilar:** _____	◯ 100 mg/mL	◯ **Initial:** Infuse 5 mg/kg = _____ mg IV at weeks 0, 2, and 6 ◯ **Maintenance:** 5 mg/kg = _____ mg IV every 8 weeks ◯ Other:_____		
◯ **SKYRIZI®** (risankizumab) ◯ **SKYRIZI® On-body** (risankizumab)	◯ 600 mg vial ◯ 180 mg ◯ 360 mg	**Initial:** ◯ Infuse 600 mg IV at weeks 0, 4 and 8 ◯ Infuse 1200 mg IV at weeks 0, 4 and 8 **Maintenance:** ◯ Inject 180 mg subq at week 12 and every 8 weeks ◯ Inject 360 mg subq at week 12 and every 8 weeks		
◯ **SIMPONI®** (golimumab) ◯ **PFS** ◯ **Pen**	◯ 100 mg/mL	**Initial:** ◯ Inject 200 mg subq at week 0 ◯ Inject 100 mg subq at week 2 ◯ **Maintenance:** Inject 100 mg subq every 4 weeks		

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Medication	Dose	Directions for Use	Qty	Refills
◯ **STELARA®** (ustekinumab) ◯ **STELARA®** (ustekinumab) ◯ **PFS** ◯ **Pen** ◯ **Other biosimilar:** _____	◯ 130 mg/26 mL vial ◯ 90 mg/mL	Initial: ◯ </= 55 kg: Infuse 260 mg IV one time ◯ > 55-85 kg: Infuse 390 mg IV one time ◯ > 85 kg: Infuse 520 mg IV one time ◯ **Maintenance:** Inject 90 mg subq every 8 weeks		
◯ **TREMFYA®** (guselkumab) ◯ **TREMFYA®** (guselkumab) ◯ **PFS** ◯ **Pen**	◯ 200 mg/20 mL vial ◯ 100 mg/mL	Initial: ◯ Infuse 200 mg IV on week 0, 4, and 8 ◯ Inject 400 mg subq (2 consecutive injections) on week 0, 4, and 8 (option for Crohn's only) Maintenance: ◯ Inject 100 mg subq every 8 weeks from week 16 ◯ OR: Inject 200 mg subq every 4 weeks from week 12		
◯ **XIFAXAN®** (rifamixin)	◯ 550 mg tablet	◯ Take one tablet by mouth three times per day x 14 days ◯ 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** _____