HOME INFUSION GROUP

# GASTROENTEROLOGY REFERRAL FORM

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**PATIENT INFORMATION**

Patient Name: ______________________________
Home Address: ______________________________
City, State, Zip: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
SS: ______________________________
Date of Birth: ________________ Gender: ☐ Male ☐ Female
Contact Name & #: ______________________________

**PRESCRIBER INFORMATION**

Prescriber Name: ______________________________
Home Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________
DEA: ________________ License#: ________________
NPI #: ______________________________

**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: __________ Group: __________

**DIAGNOSIS**

| Crohn's Disease | Ulcerative Colitis | Prior Therapy (☐Yes ☐ No) |
|---|---|---|
| ☐ K50.00 Crohn's of Small Intestine | ☐ K51.0 Ulcerative Pancolitis | ☐ MTX ☐ Azathioprine |
| ☐ K50.10 Crohn's of Large Intestine | ☐ K51.2 Ulcerative Proctitis | ☐ Corticosteroid ☐ 6-MP |
| ☐ K50.80 Crohn's of Small & Large Intestine | ☐ K51.3 Ulcerative Rectosigmoiditis | ☐ Sulfasalazine ☐ NSAID's |
| ☐ K50.90 Crohn's Disease | ☐ K51.5 Left Sided Colitis | ☐ BIOLOGICs:________________ |
| ☐ Other: ________________ | ☐ K51.8 Other Ulcerative Colitis | Start Date: ________________ |
| | ☐ K51.9 Ulcerative Colitis ☐ Other________ | End Date:________________ |

**PATIENT EVALUATION**

Patient Weight: ____________ Kg/ Lbs. Height: __________ Inches/CM Allergies: ______________ ______________
Does patient have any active Infection? ☐ Yes ☐ No **Date of** ☐ negative ☐ positive **TB Test**:__________

**PRESCRIPTION INFORMATION**

| Medication | Dose and Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ Cimzia© (Certolizumab) | ☐ Cimzia Starter kit<br>☐ 200mg Vial | ☐ Induction Dose: 400mg SC on Day 1 and at weeks 2 and 4<br>☐ Maintenance Dose: Inject 400 mg SC every 4 weeks | ____days<br>____weeks | |
| ☐ Entyvio© (Vedolizumab) | ☐ 300mg single dose vial in 250 mL of 0.9% NS | ☐ Induction Dose: 300mg IV at week 0, week 2, and week 6<br>☐ Maintenance Dose: 300mg IV every 8 weeks | ____days<br>____weeks | |
| ☐ Humira© (Adalimumab) | ☐ 40 mg Starter pack<br>☐ 20 mg ☐ 40mg Syringe | ☐ Induction Dose: 160mg SC on Day 1, then 80 mg on Day 15<br>☐ Maintenance Dose: 40mg SC every 2 weeks | ____days<br>____weeks | |
| ☐ Orencia© (Abatacept) | ☐ 125 mg Syringe<br>☐ 250 mg Vials | ☐ 125 mg SC once a week<br>☐ Induction Dose: Infuse ________mg Day 1, week 2, and week 4<br>☐ Maintenance Dose: Infuse ________mg every 4 weeks | ____days<br>____weeks | |
| ☐ Remicade© (Infliximab) | ☐ 100mg / 20 ml vial in 250 mL of 0.9% NS | ☐ Induction Dose: IV at 5mg/kg (Dose = ___mg) at 0, 2 and 6 weeks<br>☐ Maintenance Dose: IV at 5mg/kg (Dose = _____mg) every 8 weeks | ____days<br>____weeks | |
| ☐ Simponi-Aria© (Golimumab) | ☐ 50 mg/ml vial<br>☐ 100 mg/ml vial | ☐ Induction Dose: 200mg SC week 0, then 100 mg week 2<br>☐ Maintenance Dose: Inject 100 mg SC every 4 weeks | ____days<br>____weeks | |
| ☐ Stelara© (Ustekinumab) | ☐ 130 mg/26 ml vial | ☐ Pts ≤55 kg: 260 mg as single dose<br>☐ Pts >55 kg to 85 kg: 390 mg as single dose<br>☐ Pts >85 kg: 520 mg as single dose<br>☐ Maintenance Dose: Inject 90 mg SC every 8 weeks | _____days<br>_____weeks | |

**Other Medications**

PREMEDICATE: ☐ **Diphenhydramine (Benadryl)** _______ mg ☐ PO ☐ Inj. ☐ **APAP (Tylenol)** ______ mg PO ☐ Other: ______________
PRN for Anaphylactic Reaction: ☐ **Hydrocortisone 100mg** IV Push ☐ **Epinephrine 0.3mg IM** **Sodium Chloride 0.9%**: ☐ 250 ml ☐ 500 ml

☐ Sodium Chloride 0.9% **Flush** ☐3 ml ☐5 ml ☐10 ml ☐20 ml ☐30 ml ☐ Flush IV line before and after infusion
☐ Heparin Flush **10** units/ml ☐3 ml ☐5 ml ☐ Heparin Flush **100** units/ml ☐3 ml ☐ 5 ml ☐ Flush IV line after infusion

**NURSING: Requires Placement ☐ PIV ☐ Midline IV Line for administration and nurse to administer infusion in home**

**Current IV Access**: ☐PIV ☐PICC ☐Midline ☐PORT ☐OTHER _______ ___# **Number of Lumens** Delivery Method: ☐ Gravity ☐ Infusion Pump
Therapy Start Date: _____________ Length of Therapy: ___________ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

By signing this form and utilizing our services, you are authorizing Home Infusion Group, Inc. and it's employees to serve as your authorization designated agent in dealing with medical and prescription insurance companies.

**Prescriber Signature**: ________________________________ (required) **Date:** ________________________ (required)

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