GASTROENTEROLOGY
Referral Form

Phone: (818) 390-9696 • Toll-Free: (855) 265-7850 • Fax: (855) 450-6717 • Specialty@MedicoRx.com

Today's Date:_____ Needed By Date:_____ SHIP TO: ❑ Patient ❑ Office ❑ Other_____

PATIENT INFORMATION		PRESCRIBER INFORMATION	
PATIENT NAME		**PRESCRIBER NAME**	
ADDRESS		**NPI#**	
CITY, STATE, ZIP		**DEA#**	**LICENSE#**
MAIN PHONE#	**ALT.#**	**ADDRESS**	
SOCIAL SECURITY#		**CITY, STATE, ZIP**	
DATE OF BIRTH	❑ **MALE** ❑ **FEMALE**	**PHONE#**	**FAX#**
HEIGHT **WEIGHT**	❑ **LBS** ❑ **KG**		
ALLERGIES		**CONTACT PERSON**	
OTHER MEDICATIONS			

CLINICAL INFORMATION

Diagnosis Code: ❑ K50.00 Crohn's Disease ❑ K51.90 Ulcerative Colitis ❑ 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:

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
☐ CIMZIA	❑ 200X2 prefilled syringe ❑ 200x2 LYO Powder	❑ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 ❑ Inject 400 mg subcutaneously once every 4 weeks	4 weeks supply	
☐ HUMIRA ☐ HUMIRA CITRATE-FREE	❑ Crohn's Starter Kit ❑ 40mg Pen ❑ 40mg Prefilled Syringe ❑ 80mg Pen	❑ Inject 160mg (two 80mg) SubQ on day 1 OR ❑ Two 40 mg SubQ days 1 & 2, then ❑ Week 2 inject 80mg (one 80mg or Two 40 mg injections) subcutaneously on day 15, then ❑ Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4-week supply	None
☐ REMICADE ☐ INFLIXIMAB (Inflectra)	❑ 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
☐ TYSABRI	❑ 300mg-Vial	❑ Infuse mg IV every weeks for		
☐ XIFAXAN	❑ 550mg Tablets	❑ 1 tablet by mouth twice daily	4-week supply	
☐ ENTYVIO	❑ 300mg	❑ Induction dose 300mg IV weeks 0,2,6. Maint. Dose 300mg Q8 Weeks	4-week supply	
☐ SYPRINE	❑ 250mg Capsules	❑ Take _____ capsules by mouth _____ times daily	4-weeks supply	
☐ STELARA	❑ 130mg/ml	❑ 260mg (if <56Kg), ☐390mg(if <86Kg) ☐ 560mg (if >85Kg) ❑ Maintenance dose: infuse 90 mg SQ every 8 weeks		
☐ OTHER				

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

By signing this form and utilizing our services, you are authorizing MedicoRX and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (**no stamps**) If Brand required check ❑ DAW_____ Initials_____ Date