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NPI: 1811550528
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GI and HEPATOLOGY, ANCILLARY REFERRAL FORM (A-M)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **K50.90** Crohn's disease, unspecified
- ☐ **K52.832** lymphocytic colitis
- ☐ **K76.82** hepatic encephalopathy
- ☐ **A04.7** enterocolitis due to *Clostridium difficile*
- ☐ **K51.91** ulcerative colitis, unspecified
- ☐ **K52.839** microscopic colitis
- ☐ **K92.2** gastrointestinal hemorrhage, unspecified
- ☐ **B96.81** *H. pylori* infection
- ☐ **K52.2** chronic diarrhea, noninfectious
- ☐ **K74.3** primary biliary cholangitis
- ☐ Other:

Labs & Procedures *(please send copies of the most recent applicable results)*

☐ CMP ☐ *C diff* toxin ☐ *C diff* PCR ☐ antimitochondrial antibody ☐ colonoscopy with tissue biopsy, date:

Treatment History

Current medication(s) with date(s) started:

Prior medication(s) with dates of use:

PRESCRIPTION

☐ **DAW**

Medication	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
☐ balsalazide	750mg capsule			
☐ budesonide	☐ 3mg DR capsule (Entocort EC) ☐ 4mg DR capsule (Tarpeyo) ☐ 6mg ER capsule (Ortikos) ☐ 9mg ER tablet (Uceris)			
☐ cholestyramine	4g packet			
☐ colestipol	☐ 5g packet ☐ 1g tablet			
☐ Dificid	200mg tablet	take 1 tablet by mouth twice daily for 10 days		
☐ mesalamine	☐ 0.375g ER capsule (Apriso) ☐ 4g rectal kit (Rowasa) ☐ 4g/60mL enema (Rowasa) ☐ 250mg ER capsule (Pentasa) ☐ 400mg DR capsule (Delzicol) ☐ 500mg ER capsule (Pentasa) ☐ 800mg DR tablet (Asacol HD) ☐ 1000mg suppository (Canasa) ☐ 1.2g DR tablet (Lialda)			

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

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GI and HEPATOLOGY, ANCILLARY REFERRAL FORM (M-Z)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **K50.90** Crohn's disease, unspecified
- ☐ **K52.832** lymphocytic colitis
- ☐ **K76.82** hepatic encephalopathy
- ☐ **A04.7** enterocolitis due to *Clostridium difficile*
- ☐ **K51.91** ulcerative colitis, unspecified
- ☐ **K52.839** microscopic colitis
- ☐ **K92.2** gastrointestinal hemorrhage, unspecified
- ☐ **B96.81** *H. pylori* infection
- ☐ **K52.2** chronic diarrhea, noninfectious
- ☐ **K74.3** primary biliary cholangitis
- ☐ Other:

Labs & Procedures *(please send copies of the most recent applicable results)*

☐ CMP ☐ *C diff* toxin ☐ *C diff* PCR ☐ antimitochondrial antibody ☐ colonoscopy with tissue biopsy, date:

Treatment History

Current medication(s) with date(s) started:

Prior medication(s) with dates of use:

PRESCRIPTION

☐ **DAW**

Medication	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
☐ megestrol	**Susp**: ☐ 40mg/mL ☐ 400mg/10mL ☐ 625mg/5mL ☐ 800mg/20mL **Tabs**: ☐ 20mg ☐ 40mg			
☐ octreotide	**IM kit**: ☐ 20mg ☐ 30mg **PFS**: ☐ 50µg/mL ☐ 100µg/mL **Vial**: ☐ 50µg/mL ☐ 100µg/mL ☐ 200µg/mL			
☐ sulfasalazine	☐ 500mg tab ☐ 500mg DR tab			
☐ Talicia	10mg-250mg-12.5mg caps	4 caps PO 3 times daily with food for 14 days		
☐ ursodiol	**Caps**: ☐ 200mg ☐ 300mg ☐ 400mg **Tabs**: ☐ 250mg ☐ 500mg			
☐ vancomycin	**Caps**: ☐ 125mg ☐ 250mg **Soln**: ☐ 250mg/5mL	____ mg PO 4 times daily for ____ days		
☐ Xifaxan	550mg tablet	take 1 tablet by mouth twice daily		
Other:				

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

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Signature: Date: NPI:

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GI BIOLOGICS REFERRAL FORM (A – D)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **K20.0** Eosinophilic Esophagitis
- ☐ **K50.90** Crohn's Disease, unspecified
- ☐ **K51.90** Ulcerative Colitis, unspecified
- ☐ Other:

Clinical History

Labs & Procedures *(send copies of the most recent results)*

☐ TB ☐ HBsAg ☐ colonoscopy with tissue biopsy, date:

☐ EGD with tissue biopsy, date:
--- intraepithelial eosinophil count ☐ ≥ 15 eosinophils per HPF
☐ < 15 eosinophils per HPF

height: in/cm
weight: lb/kg

Disease Staging

☐ MAYO score:
☐ CDAI score:

Severity: ☐ mild ☐ moderate ☐ severe

Treatment History

Current medication(s) with date(s) started:
Prior medication(s) with dates of use:

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	*Route*	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
☐		*Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed*			
☐ adalimumab ☐ Abrilada ☐ Amjevita ☐ Cyltezo ☐ Hadlima ☐ Hulio ☐ Humira ☐ Hyrimoz ☐ Idacio ☐ Simlandi ☐ Yuflyma ☐ Yusimry	sub-Q	**Starter Kit (PF)** ☐ **Pen**: 80mg/0.8mL ☐ **PFS**: 80mg/0.8mL	☐ **Induction**: inject 160mg (two 80mg/0.8mL) sub-Q over 1-2 days then inject 80mg sub-Q on day 15	3	0
		Pen (PF): ☐ 40mg/0.4mL ☐ 40mg/0.8mL **PFS (PF):** ☐ 40mg/0.4mL ☐ 40mg/0.8mL	**Maintenance** ☐ inject 40mg sub-Q every 2 weeks ☐ other: mg sub-Q every weeks		
☐ Cimzia	sub-Q	☐ **Vial:** 200mg ☐ **PFS**: 6 x 200mg/mL	☐ **Induction**: 400mg sub-Q weeks 0, 2, & 4	6	0
		☐ **Vial:** 200mg **PFS**: ☐ 6 x 200mg/mL ☐ 2 x 200mg/mL	**Maintenance** ☐ inject 400mg sub-Q every 4 weeks ☐ other: mg sub-Q every weeks		
☐ Dupixent	sub-Q	**pen**: ☐ 200mg/1.14mL ☐ 300mg/2mL **PFS**: ☐ 200mg/1.14mL ☐ 300mg/2mL	☐ **Adult**: 300mg sub-Q once weekly **Pediatric**: ☐ 15 to < 30kg: 200mg every other week ☐ 30 to < 40kg: 300mg every other week ☐ ≥ 40kg: 300mg once weekly		

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

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GI BIOLOGICS REFERRAL FORM (E – R)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **K50.90** Crohn's Disease, unspecified
- ☐ **K51.90** ulcerative colitis, unspecified
- ☐ Other:

Clinical History

Labs & Procedures *(send copies of the most recent results)*

- ☐ TB ☐ HBsAg
- ☐ colonoscopy with tissue biopsy, date:

height: in/cm
weight: lb/kg

Disease Staging

- ☐ MAYO score:
- ☐ CDAI score:

Severity: ☐ mild ☐ moderate ☐ severe

Treatment History

Current medication(s) with date(s) started:
Prior medication(s) with dates of use:

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	*Route*	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
☐	*Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed*				
☐ Entyvio	☐ IV ☐ sub-Q	☐ **vial:** 300mg ☐ **pen**: 108mg/0.68mL	**Intravenous** ☐ **Induction**: 300mg IV at weeks 0, 2, & 6 ☐ **Maintenance:** 300mg IV every 8 weeks **Subcutaneous** ☐ **Induction**: 300mg IV at weeks 0 and 2 ☐ **Maintenance**: 108mg sub-Q every 2 wks		
☐ infliximab	☐ IV ☐ sub-Q	☐ **vial:** 100mg	☐ **Induction**: infuse ____mg (5mg/kg) IV at weeks 0, 2, & 6		0
☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis ☐ Zymfentra		☐ **vial**: 100mg ☐ **pen**: 120mg/mL ☐ **PFS**: 120mg/mL	**Maintenance** ☐ **IV**: ____mg (5 or 10 mg/kg) every ____ weeks beginning week 14 ☐ **inj**: 120mg mg sub-Q every 2 weeks beginning week 10		
☐ Rinvoq	PO	**Tabs**: ☐ 45mg	**Induction** ☐ **Crohn's**: 45mg once daily x 12 weeks ☐ **UC:** 45mg once daily x 8 weeks	28	0
		Tabs: ☐ 15mg ☐ 30mg	**Maintenance** ☐ **Crohn's**: ____ mg PO once daily ☐ **UC**: ____ mg PO once daily		

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

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Street: City: State: Zip:

Signature: Date: NPI:

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GI BIOLOGICS REFERRAL FORM (S)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **K50.90** Crohn's Disease, unspecified
- ☐ **K51.90** ulcerative colitis, unspecified
- ☐ Other:

Clinical History

Labs & Procedures *(send copies of the most recent results)*

- ☐ TB ☐ HBsAg
- ☐ colonoscopy with tissue biopsy, date:

height: in/cm
weight: lb/kg

Disease Staging

- ☐ MAYO score:
- ☐ CDAI score:

Severity: ☐ mild ☐ moderate ☐ severe

Treatment History

Current medication(s) with date(s) started:
Prior medication(s) with dates of use:

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	Route	Dose/Strength	Directions/Sig	Quantity	Refills
☐	*Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed*				
☐ Simponi	sub-Q	☐ **pen:** 100mg/mL ☐ **PFS**: 100mg/mL	☐ **Induction**: inject 200mg at week 0 then inject 100mg at week 2 **Maintenance** ☐ inject 100mg sub-Q every 4 weeks ☐ other: mg every wks		0
☐ Skyrizi *Crohn's*	IV	☐ **vial:** 600mg/10mL	☐ **Induction**: 600mg IV at weeks 0, 4, & 8	30	0
	sub-Q	**OBJ**: ☐ 180mg/1.2mL ☐ 360mg/2.4mL	☐ **Maintenance:** mg sub-Q every 8 weeks		
☐ Skyrizi *UC*	IV	**vial:** 600mg/10mL	☐ **Induction**: 1,200mg IV at weeks 0, 4, & 8	60	0
	sub-Q	**OBJ**: ☐ 180mg/1.2mL ☐ 360mg/2.4mL	☐ **Maintenance**: mg sub-Q every 8 weeks		
☐ Stelara	IV	☐ **vial:** 130mg/26mL	☐ **Induction**: infuse IV as a single dose ☐ 260mg (≤55kg) ☐ 390mg (55-858kg) ☐ 520mg (> 85kg)		0
	sub-Q	☐ **PFS**: 90mg/mL	☐ **Maintenance**: 90mg sub-Q every 8 weeks		

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

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GI BIOLOGICS REFERRAL FORM (T – Z)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **K50.90** Crohn's Disease, unspecified
- ☐ **K51.90** ulcerative colitis, unspecified
- ☐ Other:

Clinical History

Labs & Procedures *(send copies of the most recent results)*

- ☐ TB ☐ HBsAg ☐ CMP ☐ CBC
- ☐ colonoscopy with tissue biopsy, date:

height: in/cm
weight: lb/kg

Disease Staging

- ☐ MAYO score:
- ☐ CDAI score:

Severity: ☐ mild ☐ moderate ☐ severe

Treatment History

Current medication(s) with date(s) started:
Prior medication(s) with dates of use:

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	*Route*	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
☐	*Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed*				
☐ Tremfya	IV	☐ **vial**: 200mg/20mL	☐ **Induction**: 200mg IV at weeks 0, 4, and 8	60	0
	sub-Q	**pen**: ☐ 100mg/mL ☐ 200mg/2mL **PFS**: ☐ 100mg/mL ☐ 200mg/2mL	☐ **Maintenance**: ☐ 100mg sub-Q every 8 weeks ☐ 200mg sub-Q every 4 weeks		
☐ Xeljanz	PO	**IR Tabs**: ☐ 5mg ☐ 10mg **XR Tabs**: ☐ 11mg ☐ 22mg	**Induction** ☐ **IR**: 10mg PO BID for ____ weeks ☐ **ER**: 22mg PO once daily for ____ weeks		
		IR Tabs: ☐ 5mg ☐ 10mg **XR Tabs**: ☐ 11mg ☐ 22mg	**Maintenance** ☐ **IR**: 5mg PO BID ☐ **ER**: 11mg PO once daily ☐ other:		
Other: ☐					

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

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IRRITABLE BOWEL SYNDROME REFERRAL FORM

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **A04.9** small intestine bacterial overgrowth (SIBO)
- ☐ **K58** irritable bowel syndrome (IBS), unspecified
- ☐ **K58.0** irritable bowel syndrome with diarrhea (IBS-D)
- ☐ **K58.1** irritable bowel syndrome with constipation (IBS-C)
- ☐ **K59.03** opioid-induced constipation (OIC)
- ☐ **K59.04** chronic idiopathic constipation (CIC)
- ☐ Other: _____

• If the diagnosis is SIBO, has the patient completed a diagnostic breath test? If yes, *please include results*.	☐ yes	☐ no
• If the diagnosis is IBS-D, has the patient failed a ≥ 3 month trial of dietary (low FODMAP diet) and lifestyle modifications?	☐ yes	☐ no
• If the diagnosis is IBS-C, OIC, or CIC, has the patient failed a ≥ 3 month trial of dietary (increased water, fiber) and lifestyle (increased exercise) modifications?	☐ yes	☐ no
• If the diagnosis is OIC, is the patient using the opioid(s) for chronic, non-cancer pain?	☐ yes	☐ no
• If the diagnosis is OIC, is the patient on a stable opioid dose not requiring frequent titrations?	☐ yes	☐ no

PRESCRIPTION

☐ **DAW**

Medication	*Product*	*Directions/Sig*	*Quantity*	*Refills*
Constipation				
☐ Ibsrela	50mg tab	1 tablet PO twice daily before meals		
☐ Linzess	**Caps:** ☐ 72mcg ☐ 145mcg ☐ 290mcg	1 capsule PO once daily 30 min before first meal		
☐ lubiprostone (Amitiza)	**Caps:** ☐ 8mcg ☐ 24mcg	1 capsule PO twice daily with meals		
☐ Motegrity	**Tabs:** ☐ 1mg ☐ 2mg	1 tablet PO once daily		
☐ Movantik	**Tabs:** ☐ 12.5mg ☐ 25mg	1 tablet PO once daily 1-2 hours before first meal		
☐ Relistor	**Vial:** ☐ 8mg/0.4mL ☐ 12mg/0.6mL **Tabs:** ☐ 150mg tab	sub-Q: ____ mg every ____ day(s) PO: ____ mg PO once daily		
☐ Symproic	0.2mg tab	1 tablet PO once daily		
☐ Trulance	3mg tab	1 tablet PO once daily		
Diarrhea				
☐ alosetron	**Tabs:** ☐ 0.5mg ☐ 1mg			
☐ Xifaxan	550mg tab	1 tablet PO three times daily for 14 days		
Other:				

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

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