Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

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:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

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:

Street: City: State: Zip:

Signature: Date: NPI:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

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:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.

SYNERGEN Rx Specialty Pharmacy

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

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:

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

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

GI BIOLOGICS REFERRAL FORM (S – T)

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		
☐ 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		

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

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

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.

SYNERGEN Specialty Pharmacy Rx

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

GI BIOLOGICS REFERRAL FORM (U – 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*				
☐ ustekinumab ☐ Pyzchiva ☐ Stelara ☐ Selarsdi ☐ Yesintek	IV	☐ **vial:** 130mg/26mL	☐ **Induction**: infuse ☐ IV as a single dose ☐ 260mg (≤55kg) ☐ 390mg (55-858kg) ☐ 520mg (> 85kg)	60	0
	sub-Q	☐ **PFS**: 90mg/mL	☐ **Maintenance**: 90mg sub-Q every 8 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:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.

SYNERGEN Rx Specialty Pharmacy

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

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:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.