

# 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  **A04.7** enterocolitis due to *Clostridium difficile*  **B96.81** *H. pylori* infection

**K52.832** lymphocytic colitis  **K51.91** ulcerative colitis, unspecified  **K52.2** chronic diarrhea, noninfectious

**K76.82** hepatic encephalopathy  **K52.839** microscopic colitis  **K74.3** primary biliary cholangitis

**K92.2** gastrointestinal hemorrhage, unspecified  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
<input type="checkbox"/> balsalazide	750mg capsule			
<input type="checkbox"/> budesonide	<input type="checkbox"/> 3mg DR capsule (Entocort EC) <input type="checkbox"/> 4mg DR capsule (Tarpeyo) <input type="checkbox"/> 6mg ER capsule (Ortikos) <input type="checkbox"/> 9mg ER tablet (Uceris)			
<input type="checkbox"/> cholestyramine	4g packet			
<input type="checkbox"/> colestipol	<input type="checkbox"/> 5g packet <input type="checkbox"/> 1g tablet			
<input type="checkbox"/> fidaxomylin (Dificid)	200mg tablet	take 1 tablet by mouth twice daily for 10 days		
<input type="checkbox"/> mesalamine	<input type="checkbox"/> 0.375g ER capsule (Apriso) <input type="checkbox"/> 4g rectal kit (Rowasa) <input type="checkbox"/> 4g/60mL enema (Rowasa) <input type="checkbox"/> 250mg ER capsule (Pentasa) <input type="checkbox"/> 400mg DR capsule (Delzicol) <input type="checkbox"/> 500mg ER capsule (Pentasa) <input type="checkbox"/> 800mg DR tablet (Asacol HD) <input type="checkbox"/> 1000mg suppository (Canasa) <input type="checkbox"/> 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: \_\_\_\_\_

# 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  **A04.7** enterocolitis due to *Clostridium difficile*  **B96.81** *H. pylori* infection

**K52.832** lymphocytic colitis  **K51.91** ulcerative colitis, unspecified  **K52.2** chronic diarrhea, noninfectious

**K76.82** hepatic encephalopathy  **K52.839** microscopic colitis  **K74.3** primary biliary cholangitis

**K92.2** gastrointestinal hemorrhage, unspecified  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
<input type="checkbox"/> megestrol	<b>Susp:</b> <input type="checkbox"/> 40mg/mL <input type="checkbox"/> 400mg/10mL <input type="checkbox"/> 625mg/5mL <input type="checkbox"/> 800mg/20mL <b>Tabs:</b> <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg			
<input type="checkbox"/> octreotide	<b>IM kit:</b> <input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <b>PFS:</b> <input type="checkbox"/> 50µg/mL <input type="checkbox"/> 100µg/mL <b>Vial:</b> <input type="checkbox"/> 50µg/mL <input type="checkbox"/> 100µg/mL <input type="checkbox"/> 200µg/mL			
<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> 500mg tab <input type="checkbox"/> 500mg DR tab			
<input type="checkbox"/> Talicia	10mg-250mg-12.5mg caps	4 caps PO 3 times daily with food for 14 days		
<input type="checkbox"/> ursodiol	<b>Caps:</b> <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg <input type="checkbox"/> 400mg <b>Tabs:</b> <input type="checkbox"/> 250mg <input type="checkbox"/> 500mg			
<input type="checkbox"/> vancomycin	<b>Caps:</b> <input type="checkbox"/> 125mg <input type="checkbox"/> 250mg <b>Soln:</b> <input type="checkbox"/> 250mg/5mL	_____ mg PO 4 times daily for _____ days		
<input type="checkbox"/> 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: \_\_\_\_\_





# GI BIOLOGICS REFERRAL FORM (E - Q)

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

## PATIENT INFORMATION (please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> F	DoB:	
Street:		City:		State:	Zip:
Phone:	Phone:	Allergies:			

## CLINICAL INFORMATION (please attach clinical notes and labs)

<b>Diagnosis with ICD-10 code</b> <input type="checkbox"/> <b>K50.90</b> Crohn's Disease, unspecified <input type="checkbox"/> <b>K51.90</b> ulcerative colitis, unspecified <input type="checkbox"/> Other: _____	<b>Clinical History</b> <hr/> <b>Labs &amp; Procedures</b> <i>(send copies of the most recent results)</i> <input type="checkbox"/> TB <input type="checkbox"/> HBsAg <input type="checkbox"/> colonoscopy with tissue biopsy, date: _____
height: _____ in/cm weight: _____ lb/kg	<b>Disease Staging</b> <input type="checkbox"/> MAYO score: _____ <input type="checkbox"/> CDAI score: _____
<b>Severity:</b> <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> 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	DirmmLLections/Sig	Quantity	Refills
<input type="checkbox"/> Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed					
<input type="checkbox"/> Entyvio	<input type="checkbox"/> IV <input type="checkbox"/> sub-Q	<input type="checkbox"/> vial: 300mg	<b>Intravenous</b> <input type="checkbox"/> <b>Induction:</b> 300mg IV at weeks 0, 2, & 6 <input type="checkbox"/> <b>Maintenance:</b> 300mg IV every 8 weeks <b>Subcutaneous</b> <input type="checkbox"/> <b>Induction:</b> 300mg IV at weeks 0 and 2 <input type="checkbox"/> <b>Maintenance:</b> 108mg sub-Q every 2 wks		
		<input type="checkbox"/> pen: 108mg/0.68mL			
<input type="checkbox"/> infliximab	<input type="checkbox"/> IV <input type="checkbox"/> sub-Q	<input type="checkbox"/> vial: 100mg	<input type="checkbox"/> <b>Induction:</b> infuse _____mg (5mg/kg) IV at weeks 0, 2, & 6  <b>Maintenance</b> <input type="checkbox"/> <b>IV:</b> _____mg (5 or 10 mg/kg) every _____ weeks beginning week 14 <input type="checkbox"/> <b>inj:</b> 120mg mg sub-Q every 2 weeks beginning week 10		0
		<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Ixifi <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis <input type="checkbox"/> Zymfentra		<input type="checkbox"/> vial: 100mg	<input type="checkbox"/> pen: 120mg/mL
<input type="checkbox"/> Omvoh	<input type="checkbox"/> IV <input type="checkbox"/> sub-Q	<input type="checkbox"/> vial: 300mg/15mL	<b>Induction</b> <input type="checkbox"/> <b>Crohn's:</b> 900mg IV at weeks 0, 4, & 8 <input type="checkbox"/> <b>UC:</b> 300mg IV at weeks 0, 4, & 8  <b>Maintenance</b> <input type="checkbox"/> <b>Crohn's:</b> 300mg sub-Q every 4 weeks beginning week 12 <input type="checkbox"/> <b>UC:</b> 200mg sub-Q every 4 weeks beginning week 12	135mL	0
		<input type="checkbox"/> pen: <input type="checkbox"/> 100mg/mL <input type="checkbox"/> 200mg/2mL <input type="checkbox"/> PFS: <input type="checkbox"/> 100mg/mL <input type="checkbox"/> 200mg/2mL			

## PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:			
Contact Name:		Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> 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.



# GI BIOLOGICS REFERRAL FORM (R - S)

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

**PATIENT INFORMATION** (please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> F	DoB:	
Street:			City:		State:
Phone:		Phone:		Allergies:	

**CLINICAL INFORMATION** (please attach clinical notes and labs)

<b>Diagnosis with ICD-10 code</b> <input type="checkbox"/> <b>K50.90</b> Crohn's Disease, unspecified <input type="checkbox"/> <b>K51.90</b> ulcerative colitis, unspecified <input type="checkbox"/> Other: _____	<b>Clinical History</b> <hr/> <b>Labs &amp; Procedures</b> (send copies of the most recent results) <input type="checkbox"/> TB <input type="checkbox"/> HBsAg <input type="checkbox"/> colonoscopy with tissue biopsy, date: _____
height: _____ in/cm weight: _____ lb/kg	<b>Disease Staging</b> <input type="checkbox"/> MAYO score: _____ <input type="checkbox"/> CDAI score: _____
<b>Severity:</b> <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> 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
<input type="checkbox"/> Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed					
<input type="checkbox"/> Rinvog	PO	Tabs: <input type="checkbox"/> 45mg	<b>Induction</b> <input type="checkbox"/> Crohn's: 45mg once daily x 12 weeks <input type="checkbox"/> UC: 45mg once daily x 8 weeks	28	
		Tabs: <input type="checkbox"/> 15mg <input type="checkbox"/> 30mg	<b>Maintenance</b> <input type="checkbox"/> Crohn's: _____ mg PO once daily <input type="checkbox"/> UC: _____ mg PO once daily		
<input type="checkbox"/> Simponi	sub-Q	<input type="checkbox"/> pen: 100mg/mL <input type="checkbox"/> PFS: 100mg/mL	<input type="checkbox"/> <b>Induction:</b> inject 200mg at week 0 then inject 100mg at week 2 <b>Maintenance</b> <input type="checkbox"/> inject 100mg sub-Q every 4 weeks <input type="checkbox"/> other: _____ mg every _____ wks		0
<input type="checkbox"/> Skyrizi <i>Crohn's</i>	IV	<input type="checkbox"/> vial: 600mg/10mL	<input type="checkbox"/> <b>Induction:</b> 600mg IV at weeks 0, 4, & 8	30 mL	0
	sub-Q	<b>OBJ:</b> <input type="checkbox"/> 180mg/1.2mL <input type="checkbox"/> 360mg/2.4mL	<input type="checkbox"/> <b>Maintenance:</b> _____ mg sub-Q every 8 weeks		
<input type="checkbox"/> Skyrizi <i>UC</i>	IV	<input type="checkbox"/> vial: 600mg/10mL	<input type="checkbox"/> <b>Induction:</b> 1,200mg IV at weeks 0, 4, & 8	60 mL	0
	sub-Q	<b>OBJ:</b> <input type="checkbox"/> 180mg/1.2mL <input type="checkbox"/> 360mg/2.4mL	<input type="checkbox"/> <b>Maintenance:</b> _____ mg sub-Q every 8 weeks		

**PRESCRIBER INFORMATION**

Prescriber:		Supervising Physician:			
Contact Name:		Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email:			
Phone:		Ext:		Fax:	
Street:		City:		State:	
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.

# GI BIOLOGICS REFERRAL FORM (T - V)

## PATIENT INFORMATION (please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> F	DoB:	
Street:			City:	State:	Zip:
Phone:	Phone:	Allergies:			

## CLINICAL INFORMATION (please attach clinical notes and labs)

<b>Diagnosis with ICD-10 code</b> <input type="checkbox"/> <b>K50.90</b> Crohn's Disease, unspecified <input type="checkbox"/> <b>K51.90</b> ulcerative colitis, unspecified <input type="checkbox"/> Other: _____	<b>Clinical History</b> <hr/> <b>Labs &amp; Procedures</b> (send copies of the most recent results) <input type="checkbox"/> TB <input type="checkbox"/> HBsAg <input type="checkbox"/> colonoscopy with tissue biopsy, date: _____
height: _____ in/cm weight: _____ lb/kg	<b>Disease Staging</b> <input type="checkbox"/> MAYO score: _____ <input type="checkbox"/> CDAI score: _____
<b>Severity:</b> <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> 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
<input type="checkbox"/> Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed					
<input type="checkbox"/> Tremfya	<input type="checkbox"/> IV <input type="checkbox"/> sub-Q	<input type="checkbox"/> vial: 200mg/20mL <input type="checkbox"/> pen: 200mg/2mL <input type="checkbox"/> PFS: 200mg/2mL	<b>Induction</b> <input type="checkbox"/> <b>IV:</b> 200mg IV at weeks 0, 4, & 8 <input type="checkbox"/> <b>inj:</b> 400mg sub-Q at weeks 0, 4, & 8		
	sub-Q	<b>pen:</b> <input type="checkbox"/> 100mg/mL <input type="checkbox"/> 200mg/2mL <b>PFS:</b> <input type="checkbox"/> 100mg/mL <input type="checkbox"/> 200mg/2mL	<b>Maintenance:</b> <input type="checkbox"/> 100mg sub-Q every 8 weeks beginning week 16 <input type="checkbox"/> 200mg sub-Q every 4 weeks beginning week 12		
<input type="checkbox"/> ustekinumab <input type="checkbox"/> Imuldosa <input type="checkbox"/> Otulfi <input type="checkbox"/> Pyzchiva <input type="checkbox"/> Selarsdi <input type="checkbox"/> Starjemza <input type="checkbox"/> Stelara <input type="checkbox"/> Steqeyma <input type="checkbox"/> Wezlana <input type="checkbox"/> Yesintek	IV	<input type="checkbox"/> vial: 130mg/26mL	<input type="checkbox"/> <b>Induction:</b> infuse _____ IV as a single dose <input type="checkbox"/> 260mg (≤55kg) <input type="checkbox"/> 390mg (55-85kg) <input type="checkbox"/> 520mg (> 85kg)		
	sub-Q	<input type="checkbox"/> PFS: 90mg/mL	<b>Maintenance:</b> <input type="checkbox"/> 90mg sub-Q every 8 weeks <input type="checkbox"/> other: _____mg every _____ weeks		
<input type="checkbox"/> Velsipity	PO	2 mg	take 1 tablet by mouth once daily	30	

## PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:			
Contact Name:			Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email:		
Phone:		Ext:	Fax:		
Street:		City:	State:	Zip:	
Signature:		Date:	NPI:		



# IRRITABLE BOWEL SYNDROME REFERRAL FORM

## PATIENT INFORMATION (please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> 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
<b>Constipation</b>				
<input type="checkbox"/> Ibsrela	50mg tab	1 tablet PO twice daily before meals		
<input type="checkbox"/> Linzess	<b>Caps:</b> <input type="checkbox"/> 72mcg <input type="checkbox"/> 145mcg <input type="checkbox"/> 290mcg	1 capsule PO once daily 30 min before first meal		
<input type="checkbox"/> lubiprostone (Amitiza)	<b>Caps:</b> <input type="checkbox"/> 8mcg <input type="checkbox"/> 24mcg	1 capsule PO twice daily with meals		
<input type="checkbox"/> Movantik	<b>Tabs:</b> <input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg	1 tablet PO once daily 1-2 hours before first meal		
<input type="checkbox"/> prucalopride (Motegrity)	<b>Tabs:</b> <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg	1 tablet PO once daily		
<input type="checkbox"/> Relistor	<b>Vial:</b> <input type="checkbox"/> 8mg/0.4mL <input type="checkbox"/> 12mg/0.6mL	_____ mg sub-Q every _____ day(s)		
	<b>Tabs:</b> <input type="checkbox"/> 150mg tab	_____ mg PO once daily		
<input type="checkbox"/> Symproic	0.2mg tab	1 tablet PO once daily		
<input type="checkbox"/> Trulance	3mg tab	1 tablet PO once daily		
<b>Diarrhea</b>				
<input type="checkbox"/> alosetron	<b>Tabs:</b> <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg			
<input type="checkbox"/> Xifaxan	550mg tab	1 tablet PO three times daily for 14 days		
<b>Other:</b>				

## PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:			
Contact Name:		Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email:			
Phone:		Ext:	Fax:		
Street:		City:		State:	Zip:
Signature:		Date:		NPI:	