PERFORMSPECIALTY®
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Gastroenterology Referral Form

Fax: 1-844-489-9565 | Phone: 1-855-287-7888 | www.performspecialty.com

Patient

Patient name:				
Date of birth:	□ Male □ Female	Height:	Weight: lb	kg
Address:		City:	State:	ZIP:
Home number:	Work number:	Cell number:	Best time to call: □ a.m. □ p.m.	
Last 4 of SS :		Ethnicity:		
Primary language:	Allergies:		□ No known drug allergies	

Provider

Physician name:	Practice name:		
State license number:	Drug Enforcement Administration (DEA) number:		
Address:	City:	State:	ZIP:
National Provider Identifier (NPI) number:	Phone:	Fax:	
Key office contact:		Phone:	

Insurance

***Please provide a copy of the insurance card (front and back)**

Clinical information

□ Crohn's Disease (ICD: k50.00) □ Ulcerative colitis (ICD: k51.90) □ Fistula (ICD: k63.2) □ Other (ICD:)

TB/PPD Test: □ No □ Yes □ N/A	Test date:	Injection training needed? □ No □ Yes	HBV Positive? □ No □ Yes
Previously treated: □ Yes □ No If yes, please list therapy:			Dates:

Prescription information

Medication	Dose/Strength	SIG	Quantity	Refills
□ Cimzia®	200mg/mL □ PFS □ vial □ Starter kit	□ Starter Kit: 400mg SubQ at 0, 2, & 4 weeks □ 400mg SubQ every 4 weeks	□ Starter Kit □1 month	
□Entyvio	□ 300mg VIal	□ Infuse 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks □ Infuse 300mg every 8 weeks	Vial(s)	
□ Humira®	□ 40mg/0.8ml Starter Kit (6 Pens) □ 80mg/0.8ml CF Starter Kit (3 Pens) □ 40mg/0.8ml PEN □ 40mg/0.8ml PFS □ 40mg/0.4ml PEN □ 40mg/0.4ml PFS	□Starting Dose: Inject SubQ 160 mg on day 1, then 80 mg on day 15, then maintenance on day 29 □ Inject 40mg SubQ every 2 weeks	□ Starter Kit □ 1 month	
□ Remicade® □Renflexis □Inflectra	□ 100mg vial Dose: mg/kg	□ Initial: Infuse mg IV at 0, 2, & 6 weeks then mg every weeks □ Maintenance: Infuse mg IV every weeks	vial(s)	
□ Simponi®	□ 100mg Pen □ 100mg PFS	□Starting Kit: Inject SubQ 200 mg initially (given as 2 subcutaneous injections of 100 mg each) at Week 0, followed by 100 mg at Week 2 and then 100 mg every 4 weeks □ Inject 100mg SubQ q month	Pen(s) 1 month	
□ Stelara®	□ 130 mg/26 mL vial □ 90mg/mL PFS	□ 55 kg or less 260 mg at Week 0 □ 55 kg to 85 kg 390 mg at Week 0 □ more than 85 kg 520 mg at Week 0 □ Maintenance: Inject 90 mg SubQ 8 weeks after the initial IV induction dose, then every 8 weeks thereafter	Vial(s) 1 month	
□ Xelianz® □ Xelianz XR®	□ 5mg tablet □ 11mg tablet	□ Take 10 mg by mouth twice daily for at least 8 weeks; followed by 5 or 10 mg twice daily □Take 1 tablet by mouth twice daily with or without food □Take 1 tablet by mouth once daily, with or without food	1 month	
□ Other				

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS. (STAMPS NOT ACCEPTED)

Prescriber signature: o Dispense as written Do not substitute o Substitution permitted/Branded exchange permitted Date:

For states requiring handwritten expressions of product selection, use this area (eg medically necessary, may not substitute, dispense as written, etc)