

## Gastroenterology Referral Form

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

Access.Outco	omes. Personalized Care.					.,	
Patient							
Patient name:							
Date of birth:	□ Male □ Female		Height: Weight:		Weight:	b	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			25		
Provider		7 morgios.			- Tro known drug dhorgic	,,,	
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	f the insurance card (front and back)						
Clinical informa	tion						
	0.00) Ulcerative colitis (ICD: k51.90) Fistula			l			
TB/PPD Test: □ No □ Yes		Injection training needed? □ No □ Yes HBV Positive? □ No □ Yes					
Previously treated: 🗆 Yes 🗆 No If yes, please list therapy: Dates:							
Prescription info	ormation						
Medication	Dose/Strength	SIG				Quantity	Refills
□ Cimzia®		200mg/mL				□ Starter Kit	_
	ŭ .						
						□1 month	
□Entyvio	□Entyvio □ 300mg Vlal □ 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)		□Starting Dose: Inject SubQ 160 mg on day 1, then 80 mg on day 15, then maintenance on day 29				
□ Hullilla⊎	□ 80mg/0.8ml CF Starter Kit ( 3 Pens)	□ Inject 40mg SubQ every 2 weeks				□ Starter Kit	
						□ 1 month	
	□ 40mg/0.8ml PEN □ 40mg/0.8ml PFS						
	□ 40mg/0.4ml PEN □ 40mg/0.4ml PFS						
□ Remicade®	□ 100mg vial						
□Renflexis □Inflectra	Dose: mg/kg	□ Maintenance: Infuse	mg IV every weeks				
□ Simponi®	□ 100mg Pen □ 100mg PFS	□Starting Kit: Inject SubQ 200 mg initially (given as 2 subcutaneous injections of 100 mg each) at Week 0				Pen(s)	
		followed by 100 mg at Week 2 and then 100 mg every 4 weeks  □ Inject 100mg SubQ q month					
		, , ,				1 month	
□ Stelara®	□ 130 mg/26 mL vial	□ 55 kg or less 260 mg at	at Week 0	☐ Maintenance: Inject 90 m	ng SubQ 8 weeks after the en every 8 weeks thereafter	r Vial(s)	
	□ 90mg/mL PFS	□ 55 kg to 85 kg 390 mg and a more than 85 kg 520 mg		illiliai IV illiduction dose, the		viai(s)	
			9			1 month	
□ Xelianz®	5mg tablet	□ Take 10 mg by mouth twice daily for at least 8 weeks; followed by 5 or 10 mg twice daily				1 month	
□ Xelianz XR®	□ 11mg tablet	□ Take 1 tablet by mouth twice daily with or without food □ Take 1 tablet by mouth once daily, with or without food				T monu	
□ Other							
DDECODIDED OLONIATUR	DE DECODIDED CIONATURE IO DECUMPE	TO VALIDATE PRESCRIP	TIONIC (OTAMBONICE	ACCEPTED)			
	RE: PRESCRIBER SIGNATURE IS REQUIRED		`	ACCEPTED) stitution permitted/Branded e	vohange nermitted	Date:	
Prescriber signature:	o Dispe	nse as written Do not subst		outunon permitteu/Diantied e.	nonanye pennilleu l	Jait.	
For states requiring handwritten expr	ressions of product selection, use this area (eg medically ne	cessary, may not substitute, disper	nse as written, etc)				
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