EL NORTE
Retail & Specialty Pharmacy

GASTROENTEROLOGY REFERRAL FORM

Phone: (760) 233-2100
Fax: (760-233-2105

Ship To: ❑ Patient ❑ Physician / Clinic ❑ Pick Up ❑ Date Needed: _____ **Injection Training Needed:** ❑ Yes ❑ No

PATIENT INFORMATION					PRESCRIBER INFORMATION	
	Patient Name				**Prescriber Name**	
	Address				**NPI**	
	City, State, Zip				**Address**	
	Primary Phone		**Alt. Phone**		**City, State, Zip**	
	Date of Birth		**Allergies**		**Office Phone:**	
	Height/ Weight		**Sex:**	❑ Male ❑ Female	**Office Fax:**	
	Insurance	**PLEASE FAX A COPY OF INSURANCE CARD(S)**			**Contact Person**	

CLINICAL INFORMATION

Diagnosis: ❑ Crohns ❑ Ulcerative Colitis ❑ Hepatitis B ❑ Hepatitis C ICD10 Code: _____ ❑ Other: _____

PPD/Chest X-Ray for TB ❑ Yes ❑ No Date of Negative TB test: _____ **Does patient have active infection/malignancy?** ❑ Yes ❑ No

Hepatitis B Test: ❑ **Positive** ❑ Negative **Does patient have CHF** ❑ Yes ❑ No

Tried/Failed Previous Therapies: DMARDS ❑ Yes ❑ No Please List: _____ If no, please explain why: _____
Biologics: ❑ Yes ❑ No Please List: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **CIMZIA**	❑ Cimzia Starter Kit (6 prefilled syringes)	❑ Induction Dose: Inject 400mg SC on day 1, and week 2, and at week 4		
	❑ 200 mg/1mL PFS ❑ 200 mg vial	❑ Maintenance Dose: Inject 200mg SC every other week ❑ Maintenance Dose: Inject 400mg SC every 4 weeks ❑ Other: _____		
❑ **ENTYVIO**	❑ 300 mg vial	❑ Infuse 300mg IV over 30 minutes at weeks 0, 2, and 6 weeks then every 8 weeks thereafter		
❑ **HUMIRA**	❑ 40 mg/0.8ml Starter Kit ❑ 40 mg/0.8mL PFS ❑ 40 mg/0.8mL PEN	❑ Inject 160mg SQ day 0, then 80mg day 15, then 40mg every other week ❑ Inject 40mg SC every other week ❑ Other:_____		
❑ **REMICADE**	❑ 100 mg vial	❑ Induction Dose: Infuse _____ mg/kg in 250 mL of 0.9% NaCl at week 0, 2 and 6. ❑ Maintenance Dose: Infuse _____ mg/kg in 250 mL of 0.9% NaCl every 8 weeks.		
❑ **SIMPONI**	❑ 100 mg/0.5mL SmartJect Autoinjector ❑ 100 mg/0.5mL PFS	❑ Induction Dose: Inject 100mg SC once at week 0, week 14, then every 4 weeks thereafter ❑ Maintenance Dose: Inject 100mg SC every 4 weeks		
❑ **STELARA**	❑ 5 mg/mL vial ❑ 45 mg/0.5mL vial ❑ 45 mg/0.5mL PFS ❑ 90 mg/mL PFS	❑ For patients weighing ≤ 100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks ❑ For patients weighing > 100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks.		
❑ **BARACLUDE**	❑ 0.5 mg ❑ 1 mg	❑ Take 1 tablet daily on an empty stomach		
❑ **EPIVIR HVB**	❑ 100 mg	❑ Take 1 tablet daily		
❑ **HEPSERA**	❑ 10 mg	❑ Take 1 tablet daily		
❑ **TYZEKA**	❑ 600 mg	❑ Take 1 tablet daily		
❑ **VEMLIDY**	❑ 25 mg	❑ Take 1 tablet daily with food		
❑ **VIREAD**	❑ 300 mg	❑ Take 1 tablet daily		
❑ **OTHER**				

By signing below, I authorize El Norte Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and help the patient to apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ Date: _____