GASTROENTEROLOGY
REFERRAL FORM

Phone: (626) 966-3691 ● Fax: (626) 331-8691 ● Dedicated Texting: (626) 664-0988

Today's Date: ____________________ Needs By Date: __________________________ SHIP TO: ❑ Patient ❑ Office ❑ Other______________________________

PATIENT INFORMATION			PRESCRIBER INFORMATION	
PATIENT NAME			**PRESCRIBER NAME**	
ADDRESS			**NPI#**	
CITY, STATE, ZIP			**DEA#**	**LICENSE#**
MAIN PHONE#	**ALT.#**		**ADDRESS**	
SOCIAL SECURITY#			**CITY, STATE, ZIP**	
DATE OF BIRTH		**❑ MALE ❑ FEMALE**	**PHONE#**	**FAX#**
HEIGHT	**WEIGHT**	**❑ LBS ❑ KG**		
ALLERGIES			**CONTACT PERSON**	
OTHER MEDICATIONS				

CLINICAL INFORMATION

Diagnosis Code: ❑ K50.00 Crohn's Disease ❑ K51.90 Ulcerative Colitis ❑ Other: ____

History: Has the Patient been treated previously for this condition? ❑ Yes ❑ No

❑ NSAIDS	Duration:	❑ Sulfasalazine	Duration:	❑ Corticosteroid	Duration:
❑ MTX	Duration:	❑ 5-ASA (5-Aminosalicylates)	Duration:	❑ 6-MP (Mercaptopurine)	Duration:
❑ Biologics	Duration:	❑ Azathioprine	Duration:	❑ Other	Duration:

Is the patient currently on any therapy? ❑ Yes ❑ No List Meds: ____

Will patient stop taking Meds before starting the new med? ❑ Yes ❑ No How long will the patient wait before starting the new med? ____________

Has patient received PPD (skin test)? ❑ Yes ❑ No Results:

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ CIMZIA	❑ 200X2 prefilled syringe ❑ 200x2 LYO Powder	❑ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 ❑ ❑ Inject 400 mg subcutaneously once every 4 weeks	4 weeks supply	
❑ HUMIRA	❑ Crohn's Starter Kit ❑ 40mg Pen ❑ 40mg Prefilled Syringe	❑ Inject 160mg ❑ Four 40mg SubQ day 1 OR ❑ Two 40 mg SubQ days 1 & 2 then Week 2 inject 80mg (Two 40 mg injections) subcutaneously on day 15 ❑ Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	None
❑ SIMPONI	❑ 100mg SmartJect ❑ 100mg Prefilled Syringe	❑ Inject 200mg SubQ at week 0; then 100mg at week 2, 100mg every 4 weeks ❑ Inject 100mg subcutaneously once every 4 weeks	Loading dose 4 week supply	None
❑ TYSABRI	❑ 300mg-Vial	❑ Infuse mg IV every weeks for		
❑ XIFAXAN	❑ 550mg Tablets	❑ 1 tablet by mouth twice daily	4 week supply	
❑ OTHER				

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

Prescriber Authorization: I authorize Glesener Pharmacy and its representatives to act as my authorized agent to initiate the insurance prior authorization process for my patient(s), and to sign any necessary prior authorization forms on my behalf. In the event that Glesener Pharmacy is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature (no stamps) If Brand required check ❑ DAW__________ Initials__________ **Date**

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