

Gastroenterology Therapies

Referring Physician Orders Rev. 03.2025

Please fax completed referral form & all required documents to 770-618-9617



PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City/ST/Zip: _____
Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

***ICD 10 Code Required** Crohn's Disease (K50.00-K50.919), ICD10 _____ Other: _____, ICD10 _____
 Ulcerative Colitis (K51.00-K51.919), ICD10 _____

INFUSION ORDERS

| MEDICATION | DOSE | DIRECTIONS/DURATION |
|---|--|---|
| Cimzia® (certolizumab pegol) | 400mg | <input type="checkbox"/> INITIAL: Inject 400mg SUBQ at Weeks 0, 2, 4, then every 4 weeks x 1 year <input type="checkbox"/> MAINTENANCE: Inject 400mg SUBQ every 4 weeks x 1 year |
| Entyvio® (vedolizumab) | 300mg | <input type="checkbox"/> INITIAL: Infuse IV over 30 minutes at Weeks 0, 2, 6, then every 8 weeks x 1 year <input type="checkbox"/> MAINTENANCE: Infuse IV over 30 minutes every 8 weeks x 1 year |
| Infliximab and biosimilars: <input type="checkbox"/> Avsola® <input type="checkbox"/> Remicade® <input type="checkbox"/> Inflectra® <input type="checkbox"/> Renflexis® | <input type="checkbox"/> _____ mg (5 mg/kg) <input type="checkbox"/> _____ mg (10 mg/kg) <input type="checkbox"/> _____ mg (_____ mg/kg) | <input type="checkbox"/> INITIAL: Infuse IV over 2 hours at Weeks 0, 2, 6, then every 8 weeks x 1 year <input type="checkbox"/> MAINTENANCE: Infuse IV over 2 hours every 8 weeks x 1 year <input type="checkbox"/> MAINTENANCE: Infuse IV over 2 hours every _____ weeks x 1 year |
| Omvo™ (mirikizumab) | <input type="checkbox"/> 900mg (for CD) <input type="checkbox"/> 300mg (for UC) | <input type="checkbox"/> CD: Infuse 900mg IV over 90 minutes every 4 weeks x 3 doses <input type="checkbox"/> UC: Infuse 300mg IV over 30 minutes every 4 weeks x 3 doses |
| Skyrizi® (risankizumab) | <input type="checkbox"/> 600mg (for CD) <input type="checkbox"/> 1200mg (for UC) | <input type="checkbox"/> CD: Infuse 600mg IV over 1 hour every 4 weeks x 3 doses <input type="checkbox"/> UC: Infuse 1200mg IV over 2 hours every 4 weeks x 3 doses |
| Stelara® (ustekinumab) | INITIAL IV Dose: <input type="checkbox"/> <55kg – 260mg <input type="checkbox"/> 55kg to 85kg – 390mg <input type="checkbox"/> >85kg – 520mg | <input type="checkbox"/> Infuse IV over 1 hour x 1 dose |
| Tremfya® (guselkumab) | 200mg | <input type="checkbox"/> Infuse IV over 1 hour every 4 weeks x 3 doses |
| Tysabri® (natalizumab) <input type="checkbox"/> Patient enrolled in TOUCH Prescribing Program | 300mg | <input type="checkbox"/> Infuse IV over 1 hour every 4 weeks x _____ months *Observe patient for 1 hour after completion of infusion.* <input type="checkbox"/> If no hypersensitivity reaction observed with first 12 infusions, then post-infusion observations as directed by MD. |

Is patient currently receiving therapy above from another facility? NO YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____ ESR q _____ LFTs q _____ Other: _____

PRE-MEDICATION ORDERS:
 No premeds ordered at this time Diphenhydramine 25mg PO
 Acetaminophen 650mg PO Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IV
 Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
Physician Name: _____ Provider NPI: _____ Specialty: _____
Address: _____ City/ST/Zip: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Test Results (required)

- TB Screening for Cimzia, Entyvio, infliximab biosimilars, Omvoh, Skyrizi, Stelara and Tremfya (submit results from within 12 months to start and annually to continue therapy)
 - Annual TB screening to be done by: Infusion Center Referring Physician
- Hepatitis B Screening for Cimzia and infliximab biosimilars (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
 - Continuation labs to be done by: Infusion Center Referring Physician

Prior Failed Therapies (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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