VEROS HEALTH
Excellence in Complex Care

GI Referral Form

Please complete the following and fax with clinical documentation
to: 720.870.2414

Referral Process

1. PATIENT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Other Phone: _____
Email: _____
DOB: _____ Social Security #: _____
Gender: ☐ M ☐ F Height: _____ Weight: _____

2. PHYSICIAN INFORMATION

Physician's name: _____
License #: _____ NPI #: _____
DEA #: _____
Address: _____
City: _____ State: _____ Zip: _____
Office Contact: _____
Phone: _____ Fax: _____

3. DIAGNOSIS

☐ Crohn's (K50.00) ☐ Ulcerative Colitis (K51.90) ☐ Other _____
TB Test? ☐ No ☐ Yes | If yes, result: ☐ Positive ☐ Negative

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (Medication, Dosage, Duration, Pre-Medication)

Cimzia® ☐ Loading dose: Inject 400 mg SC initially and at weeks 2 and 4. # of Refills _____
☐ Inject 400 mg SC every _____ weeks. # of Refills _____
Simponi® ☐ Initial dose: Inject 200 mg SC at week 0, followed by 100 mg at week 2
☐ Maintenance doses: Inject 100 mg SC every 4 weeks. # of Refills _____
Stelara® 130 mg/26 mls (5mg/ml) single dose vials for intravenous use
Initial IV infusion: ☐ ≤55kg 260 mg IV over 1 hour x 1 dose
☐ 55kg to 85 kg 390 mg IV over 1 hour x 1 dose
☐ >85kg 520 mg IV over 1 hour x 1 dose
Stelara® for subcutaneous use
☐ 45 mg/0.5mL solution in a single-dose vial
☐ 90 mg/1 ml Prefilled Syringe
☐ Maintenance: Inject 90mg (1 ml) SC 8 weeks after initial IV infusion then every 8 weeks thereafter. Refills x _____ Months
Entyvio®
☐ 300 mg infused intravenously over approximately. 30 minutes at 0, 2 and 6 weeks, then every 8 weeks thereafter
Humira®
☐ Initially - Inject 160mg subcutaneously day one; 80mg day 15; 40mg day 29
☐ Maintenance Dose - Inject 40mg subcutaneously every other week
Injection training required? ☐Yes ☐No
Remicade®
☐ Loading dose: 5mg/kg @ 0, 2 and 6 weeks ☐Infuse in NS 250ml over 2 hours as directed
☐ Maintenance: 5mg/kg q 8 week Maintenance Dose. Refills x _____ Months.
☐ **Other** _____

6. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*
Age 1-5: 12.5mg IV/PO x1 **Age 6-11**: 25mg IV/PO x1 **Age 12+:** 50mg IV/PO x1
For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: _____

7. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.