

Inflammatory Bowel Disease REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049

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1 PATIENT'S INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: MALE FEMALE
 Address: _____ City/State/Zip: _____
 Primary Phone: _____ Email: _____ SSN: _____ Primary Language: _____
 Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

2 INSURANCE (Please attach If Available a copy of the Patients' insurance card(s) Front/ Back)

Primary Insurance: _____ Policy No: _____ Group: _____
 Primary RX Insurance: _____ ID No: _____ RX GRP: _____ RX BIN: _____ RX PCN: _____

3 DIAGNOSIS AND CLINICAL INFORMATION

Tried and failed prior therapies other than the requested Drug? Yes No If Yes, Please Specify: _____

Diagnosis (ICD-10) and Patient Clinical Information:

K50.00 Crohn's Disease of Small Intestine Without Complications K50.90 Crohn's Disease, unspecified, without complications
 K51.90 Ulcerative colitis, unspecified, without complications Other: _____ Description: _____

Drug Allergies: _____ NKDA Ht: _____ in/cm Wt: _____ lbs/Kg

Pre-Clinical Information:

TB Test Date: _____ Positive(+) Negative(-) Hepatitis-B Test Date: _____ Positive(+) Non-Reactive(-)

Labs: Please ensure labs are dated within 1 year of the patients referral request: CMP CBCw/ diff Hep-(B) QuantiFERON

4 PRESCRIPTION INFORMATION

ACCESS: IV PORT SUBCUTANEOUS N/A

PRODUCT: Avsola Adalimumab-_____ Entyvio Humira Inflectra inFLIXimab Remicade Renflexis Simponi
 Stelara Tremfya Tysabri Other: _____ Description: _____

ORAL PRODUCT: Rinvoq Velsipity Xeljanz Xeljanz XR

LOADING DOSE: _____

MAINTENANCE DOSE: _____

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input type="checkbox"/> SoluMedrol® (IV)	Give _____ mg prior to infusion via <input type="checkbox"/> IV push <input type="checkbox"/> diluted in _____ mL of NS over 30 min.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Diphenhydramine: <input type="checkbox"/> PO <input type="checkbox"/> IV	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Acetaminophen (PO)	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Hydration: <input type="checkbox"/> 0.9% NaCl <input type="checkbox"/> LR	Infuse _____ mL of _____ solution <input type="checkbox"/> before <input type="checkbox"/> after infusion.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Emla® cream	Apply topically 30 to 60 minutes prior to access.	Quantity: Q.S	Refills: PRN

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input type="checkbox"/> EPINEPHRINE (vial or autoinjector)	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 0.1 mg (Wt 7.5-15 kg)	Quantity: (x1) Vial OR (x2) Pen(s)	Refills: PRN
<input type="checkbox"/> DIPHENHYDRAMINE (50mg/mL)	Administer via IM or slow IV push for severe anaphylactic reaction. <input type="checkbox"/> 50 mg (Wt > 30 kg) <input type="checkbox"/> 25 mg (Wt 15-30 kg) <input type="checkbox"/> 12.5mg (Wt 7.5-15kg)	Quantity: (x1) Vial	Refills: PRN
<input type="checkbox"/> SODIUM CHLORIDE 0.9% (IV)	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: Q.S	Refills: PRN

NURSING/ LABS/ INFUSION SUPPLIES:

NURSING: Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.

INFUSION SUPPLIES: Infusion supplies and infusion pump PRN for the administration and disposal of medication.

FLUSHING PROTOCOL: Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.
 Heparin: 10 Units/mL 100 Units/mL, _____ as final flush and/or PRN to maintain patency

LABS: [Dx code: Z79.899]; Labs to be drawn by RN prior to infusion every _____ Week Month(s), as followed:

CMP CBC w/ diff Hepatitis-(B) Other: _____

5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: _____ Title: MD DO ND PA APRN NPI: _____
 Address: _____ City/State/Zip: _____
 Phone: _____ Fax: _____ Contact Person: _____

DISPENSE AS WRITTEN BRAND MEDICALLY NECESSARY DO NOT SUBSTITUTE May Substitute / Product Selection Permitted / Substitution Permissible
 NO SUBSTITUTION / DAW / MAY NOT SUBSTITUTE

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language.

Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to info@ivsolutionsrx.com and destroy all copies of the original message.

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE

#welcome to our family