HealthQuest Infusion & Specialty

GASTROENTEROLOGY REFERRAL FORM

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 500-3727 **F** (832) 500-8629

DATE:_____ NEXT TREATMENT DATE:_____

Please fax completed form along with copy of patient's insurance cards and any labs to (832) 500-8629

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____
Date of Birth _____ ☐ Male ☐ Female
E-mail _____

Prescriber's Name _____
DEA # _____ NPI # _____
Practice Name _____
Office Contact _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

DIAGNOSIS

Patient: Wt._____ Ht._____ Allergies: ☐ Latex ☐ Other, specify _____

ICD-10 DIAGNOSIS CODE ☐ K50.00 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other: _____

Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed: _____

Patient currently on therapy? ☐ Yes ☐ No Types/Medications: _____

Current medication, including OTC: _____ **PPD (TB Test):** ☐ Yes ☐ No Date: _____

PRESCRIPTION

DIAGNOSIS

☐ Crohn's Disease
☐ Ulcerative Colitis

Anaphylactic Reaction Orders:
- Epinephrine (based on patient weight)
  - >30kg (>66lbs): Epinephrine 0.3mg IM or subQ; may repeat in 5–10 minutes x1
  - 15–30kg (33–66lbs): Epinephrine 0.15mg IM or subQ; may repeat in 5–10 minutes x1
- Diphenhydramine: Administer 25–50mg IV (adult)
- NS 0.9% 500mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing and infusion reaction management

Flush orders: NS 1–10mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

INFUSION ORDERS

☐ **Cimzia®** 400 mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks
☐ **Cimzia®** _____ mg Sub-Q every _____ weeks
☐ **Infliximab®** Brand's available: ☐ Inflectra ☐ Remicade ☐ Renflexis
Dose: _____ mg/kg Frequency: ☐ Every ____ weeks OR ☐ 0, 2, 6 then every 8 weeks
If needed, dose to be rounded to nearest whole vial
☐ **Skyrizi®** initial infusion: ☐ 600mg IV at week 0, 4, and 8 weeks
☐ **Skyrizi®** maintenance: ☐ 360mg SQ at week 12, and every 8 thereafter (to be evaluated by HQRx)
☐ **Stelara®** initial infusion: ☐ <55kg 260mg IV over 1 hour x 1 dose
☐ 55kg to 85 kg 390mg IV over 1 hour x 1 dose ☐ >85kg 520mg IV over 1 hour x 1 dose
☐ **Stelara®** maintenance: ☐ 90mg SQ 8 weeks after initial then every 8 weeks
☐ **Tysabri®** 300 mg every 4 weeks
☐ JCV antibody ☐ Patient TOUCH authorization
☐ **Entyvio®** 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8weeks (baseline LFTs)
☐ **Entyvio®** 300mg IV every 8 weeks
☐ **Other:** _____
Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Quzyttir 10mg IVP
Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP
☐ Other: _____
Lab orders: _____
Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

REFILLS

☐ _____
☐ x 1 year

☐ Iron Deficiency Anemia
☐ Iron Deficiency Anemia with CKD not on dialysis
Required Recent Labs: CBC, Ferritin, Iron Studies

☐ **Venofer®** 200mg IV - Administer 5 doses over a 14 day period
☐ **Venofer®** 200 mg IV weekly x 5 weeks
☐ **Injectafer®** 15mg/kg IV (<50kg) - Give 2 doses at least 7 days apart
☐ **Injectafer®** 750mg IV (≥50kg) - Give 2 doses at least 7 days apart
☐ **Other:** _____

☐ _____
☐ x 1 year

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____

HealthQuest
Infusion & Specialty

COMPREHENSIVE SUPPORT FOR GASTROENTEROLOGY THERAPIES

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PATIENT INFORMATION

Patient Name _____ Date of Birth _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include **signed** and **completed** order (MD/prescriber to complete page 1)
☐ Include patient demographic information and insurance information
☐ Include patient's medication list
☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindication to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? ☐ Yes ☐ No
  If YES, which drug(s)? _____
- ☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira®, Enbrel®, Stelara®, Cimzia®)? ☐ Yes ☐ No
  If YES, which drug(s)? _____
- ☐ If psoriasis diagnosis, percent of body surface (BSA) involved: _____%

☐ Include labs and/or test results to support diagnosis
☐ If applicable - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a washout period of _____ weeks prior to starting Infliximab.
☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ TB screening test completed within 12 months - **attach results**
- ☐ Positive ☐ Negative

☐ Hepatitis B screening test completed.
This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) patient - **attach results**
- ☐ Positive ☐ Negative

**** If TB or Hepatitis B results are positive, please provide documentation of treatment or medical clearance, and a negative CXR (TB+)***

HealthQuest Infusion & Specialty will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (832) 500-8629