# Gastroenterology Therapies

**Please fax completed referral form to 972-473-7563**

## PATIENT DEMOGRAPHIC INFORMATION

Patient's name: _____ Date of birth: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Allergies: _____ Weight: _____ Height: _____

## DIAGNOSIS & CLINICAL INFORMATION

**Diagnosis**: *(ICD 10 Code Required)*

☐ Crohn's Disease (K50.00-K50.919), ICD 10_____ ☐ Ulcerative Colitis (K51.00-K51.919), ICD 10_____

☐ Other: _____

**Prior Failed Therapy:**

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

**Test Results:** Please attach copy for all items checked.

☐ Negative TB test

☐ Other: _____

**Please include copy of insurance card, most recent H&P or MD note, medication list, and lab results.**

## THERAPY ORDERED

| MEDICATION | DOSE | DIRECTIONS/DURATION |
|---|---|---|
| Cimzia® (certolizumab pegol) | **INITIAL:** 400mg<br>**MAINTENANCE:**<br>☐ 400mg<br>☐ 200mg | ☐ **INITIAL:** Inject 400mg SUBQ at Weeks 0, 2, and 4<br>☐ **MAINTENANCE:** Inject 400mg SUBQ every 4 weeks x 1 year<br>☐ **MAINTENANCE:** Inject 200mg SUBQ every 2 weeks x 1 year |
| Entyvio® (vedolizumab) | 300mg | ☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6<br>☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year |
| Remicade® (infliximab) | ☐ **5mg/kg:** _____mg<br>☐ **10mg/kg:** _____mg<br>☐ **Other:** _____mg | ☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6<br>☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year<br>☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year |
| Renflexis® (infliximab-abda) | ☐ **5mg/kg:** _____mg<br>☐ **10mg/kg:** _____mg<br>☐ **Other:** _____mg | ☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6<br>☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year<br>☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year |
| Inflectra® (infliximab-dyyb) | ☐ **5mg/kg:** _____mg<br>☐ **10mg/kg:** _____mg<br>☐ **Other:** _____mg | ☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6<br>☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year<br>☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year |
| OTHER: | | |
| OTHER: | | |

**Is patient currently receiving therapy above from another facility?** ☐ **NO** ☐ **YES** If yes, Facility Name: _____

## REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Office Contact: _____ Phone #: _____ Fax #: _____

AIR Care
Allergy, Immunology & Respiratory Care

**AIR Care | 3600 Communications Parkway | Plano, TX 75093**
**Phone 972.473.7544 | Fax 972.473.7563**

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