GI REFERRAL FORM

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Baseline liver function tests (if available)
- Negative Hep B labs

PRIMARY DIAGNOSIS

☐ K50.00	☐ K50.112	☐ K50.814	☐ K51.011	☐ K51.50
☐ K50.012	☐ K50.113	☐ K50.818	☐ K51.018	☐ K51.80
☐ K50.013	☐ K50.118	☐ K50.819	☐ K51.019	☐ K51.811
☐ K50.014	☐ K50.119	☐ K50.90	☐ K51.20	☐ K51.9
☐ K50.018	☐ K50.80	☐ K50.91	☐ K51.211	☐ K51.90
☐ K50.019	☐ K50.81	☐ K50.911	☐ K51.219	☐ K51.911
☐ K50.10	☐ K50.811	☐ K50.913	☐ K51.30	☐ K51.918
☐ K50.11	☐ K50.812	☐ K50.919	☐ K51.311	☐ K51.919
☐ K50.111	☐ K50.813	☐ K51.00	☐ K51.319	☐ K63.3

☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for the drugs listed below

☐ Provider Prescribed: _____

ENTYVIO

Induction Doses (to be administered in infusion clinic):
☐ Entyvio 300mg IV at Weeks 0, 2, 6, and every 8 weeks thereafter.
☐ Entyvio 300mg IV every _____ weeks.
☐ Other: _____

*If using subQ maintenance dosing (must have received 2 IV doses to be eligible):
☐ Infusion clinic to coordinate maintenance dose from Specialty Pharmacy:
☐ Entyvio 108mg subQ every 2 weeks
☐ Provider's office will coordinate maintenance dose from Specialty Pharmacy.

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

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INFLIXIMAB

*Remicade or biosimilar (Renflexis, Avsola, Inflectra) may be used according to payer guidelines
*To prohibit auto-substitution, please indicate specific brand required _____

☐ Infliximab 3mg/kg (_____mg) IV at Weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab 5mg/kg (_____mg) IV at Weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab 10mg/kg (_____mg) IV at Weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab _____mg/kg (_____mg) IV every _____ weeks
☐ Other: _____

*Initial calculated dose will become fixed dose throughout treatment. Check here to adjust dose per appointment ☐
*Dose will be rounded to nearest vial size (See flexcareinfusion.com for rounding protocol). To prohibit dose rounding, check here ☐
*Patient will be eligible for 1hr infusions after 6 consecutive treatments without reaction. To prohibit rapid infusions, check here ☐

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

OMVOH

Induction Doses (to be administered in infusion clinic):
☐ Omvoh 300mg IV at Weeks 0, 4, and 8.

Maintenance Doses (to be self-administered by patient):
☐ Infusion clinic will coordinate initial maintenance dose from Specialty Pharmacy: Omvoh 200mg SubQ (given as two consecutive injections of 100mg each) at Week 12 and every 4 weeks thereafter.
☐ Provider's office will coordinate maintenance dose from Specialty Pharmacy.

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

SKYRIZI

Induction Doses (To be administered in infusion clinic):
☐ Crohn's: Skyrizi 600mg IV at Weeks 0, 4, and 8
☐ UC: Skyrizi 1200mg IV at Weeks 0, 4, and 8

Maintenance Doses (To be self-administered by patient. No disease-specific dose for Crohn's or UC.):
☐ Infusion Clinic will coordinate initial maintenance dose from Specialty Pharmacy:
☐ Skyrizi 180mg subQ via on-body device at Week 12 and every 8 weeks thereafter
☐ Skyrizi 360mg subQ via on-body device at Week 12 and every 8 weeks thereafter

☐ Provider's Office will coordinate maintenance dose from Specialty Pharmacy.

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

STELARA

Ulcerative Colitis (UC) – or – Crohn's Disease (CD)

Induction Doses (to be administered in infusion clinic):
☐ Weight <55kg: Stelara 260mg IV once
☐ Weight 55kg: Stelara 390mg IV once
☐ Weight >85kg: Stelara 520mg IV once

Maintenance Doses:
☐ Infusion clinic will coordinate with SP for self-administration or administration in-clinic as payor dictates: Stelara 90mg subQ
☐ Provider's office will coordinate initial maintenance dose from SP.

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

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TREMFYA

Induction Doses (to be administered in infusion clinic):

☐ Tremfya 200mg IV at Weeks 0, 4, and 8.

Maintenance Doses (to be self-administered by patient):

☐ Infusion clinic will coordinate initial maintenance dose from Specialty Pharmacy:

☐ Tremfya subQ 200mg every 4 weeks

☐ Tremfya subQ 100mg every 8 weeks

☐ Provider's office will coordinate maintenance dose from Specialty Pharmacy.

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____

Provider Signature Date