CureStat Rx
Home Infusion and Specialty Pharmacy

Gastroenterology Referral Form

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: ____________________
DOB: __________ Gender: ☐ Male ☐ Female
Address: ____________________
City__________ State______ Zip: ______
Primary Phone: __________ SSN: __________
Caregiver Name: ____________________
Alternate Phone: ____________________

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: ____________________
State License #: __________ DEA #: __________
NPI #: __________
Address: ____________________
City__________ State______ Zip: ______
Phone: __________ Fax: __________
Contact Person: __________ Phone: __________

Insurance Information (please fax a copy of front and back of the insurance card(s))

Primary Insurance:__________ Plan ID: __________BIN #:__________ PCN #: __________ Grp #: __________
Secondary Insurance:__________ Plan ID: __________BIN #:__________ PCN #: __________ Grp #: __________

Clinical Information

Crohn's Disease: ☐ K50.0 Crohn's Disease of Small Intestine ☐ K50.1 Crohn's Disease of Large Intestine
☐ K50.8 Crohn's Disease of both intestines ☐ K50.9 Crohn's Disease, Unspecified

Ulcerative Colitis: ☐ K51.0 Ulcerative Pancolitis ☐ K51.2 Ulcerative Proctitis ☐ K51.30 Ulcerative Rectosigmoiditis
☐ K51.5 Left Sided Colitis ☐ K51.80 Other Ulcerative Colitis ☐ K51.9 Ulcerative Colitis, unspecified

Other (ICD 10 code and description): ____________________
Diagnosis Date: __________ TB/PPD test: ☐ Positive ☐ Negative Wt: ______ ☐ Kg ☐ lbs Ht: ______ ☐ cm ☐ in
Prior Therapy: ☐ Yes ☐ No ____________________
Reason for Discontinuation of therapy: ____________________
Start Date: __ __/__ __/__ __ __ __ End Date: __ __/__ __/__ __ __ __
Allergies: ☐ NKDA ☐ Other: ____________________
Comorbidities: ____________________
Concomitant Medications: ____________________

Drug	Dose/Strength	Directions	Qty	Refills
☐ **CIMZIA** (certolizumab)	☐ 200 mg/mL Prefilled Syringe ☐ 200mg Vial	☐ **Loading Dose:** Inject 400mg SC at week 0, week 2 and week 4 ☐ **Maintenance Dose:** Inject 200mg SC every 2 weeks ☐ **Maintenance Dose**: Inject 400mg SC every 4 weeks		
☐ **ENTYVIO** (Vedolizumab)	☐ 300mg Vial	☐ Infuse 300mg IV over 30 minutes at weeks 0,2 and 6. ☐ Infuse 300mg IV over 30 minutes every 8 weeks		
☐ **HUMIRA** (Adalimumab)	☐ 40mg/0.8mL Pen ☐ 40mg/0.4mL Pen ☐ 40mg/0.8mL Prefilled Syringe ☐ 40mg/0.4mL Prefilled Syringe ☐ 80 mg/0.8 mL Pen ☐ 80 mg/0.8 mL Prefilled Syringe	**Adults & Pediatric (≥ 40kg)** ☐ **Loading Dose**: Inject 160mg SC on Day 1 and then 80mg on day 15 ☐ **Maintenance Dose**: Inject 40mg SC every OTHER week **Pediatric (17kg to 40kg)** ☐ **Loading Dose:** Inject 80mg SC on Day 1 and then 40mg on day 15 ☐ **Maintenance Dose**: Inject 20mg SC every OTHER week ☐ Other: ____________________		
☐ **INFLECTRA** (Infliximab) ☐ **REMICADE** (Infliximab) ☐ **RENFLEXIS** (Infliximab)	☐ 100mg Vial	☐ **Loading Dose:** Inject __________mg (5mg/kg) IV at Weeks 0,2 and 6 ☐ **Maintenance Dose:** Inject __________mg (5mg/kg) IV every 8 weeks ☐ Other: ____________________		

Continued next page

Drug	Dose/Strength	Directions	Qty	Refills
☐ **SIMPONI** (Golimumab)	☐ 100 mg/mL Prefilled syringe ☐ 100 mg/mL Autoinjector	☐ **Loading Dose:** Inject 200mg SC at week 0 then 100mg at week 2 ☐ **Maintenance Dose**: Inject 100mg SC every 4 weeks		
☐ **STELARA** (Ustekinumab)	☐ 90 mg/mL Prefilled Syringe ☐130 mg/26 mL Vial	**Loading Dose:** For patients weighing upto 55kg: Infuse 260mg intravenously For patients weighing 55-85kg: Infuse 390mg intravenously For patients weighing >85kg: Infuse 520mg intravenously **Maintenance Dose:** Inject 90mg SC every 8 weeks		
☐ **TYSARBI** (Natalizumab)	☐ 300 mg/15 mL Vial	☐ Infuse 300mg IV over one hour every 4 weeks		
☐ **XELJIANZ** (Tocfacitinib)	☐ 5mg Tablet	☐ Give 5mg by mouth twice daily ☐ Give 10mg by mouth twice daily ☐ Other: ____		

Injection training provided by: ☐ Prescriber's office ☐ Pharmacy ☐ Other: ____________________________________

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: ____ Date: ___________________________________

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Thank you.