Gastroenterology Referral Form

Phone: 808-533-8887
Fax: 808-533-1888
E-Prescribing Available

Patient

Patient Name:______ DOB: ______ Sex: ☐ Male ☐ Female
Address: ______ City: ______ State: ______ Zip: ______
Home#: ______ Work #: ______ Cell#: ______ Best time to call: ☐ AM ☐ PM
Soc. Sec #: ______ Ethnicity: ______ Primary Language: ______
Comorbidities: ______ Height: ______ Weight:______ Date:______
Allergies: ______ ☐ NKDA

Provider

Physician Name:______ Practice Name:______ State Lic#: ______ DEA#: ______
Address:______ City:______ State:______ Zip:______ NPI#: ______
Phone#: ______ Fax#: ______ Nurse/Key Office Contact: ______ Ext.: ______

Insurance

Primary Insurance: ______ ID: ______ Phone: ______
Secondary Insurance: ______ ID: ______ Phone: ______
* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info

Diagnosis: ☐ K50.90 Crohn's disease NOS ☐ K51.90 Ulcerative Colitis ☐ Other ______ TB/PPD test given? ☐ Yes ☐ No Date: ______

Please indicate current or previous treatments and treatment duration below:

☐ Corticosteroids Duration: ______ ☐ Current Therapy ☐ Failed ☐ Sulfasalazine Duration: ______ ☐ Current Therapy ☐ Failed
☐ Methotrexate Duration: ______ ☐ Current Therapy ☐ Failed ☐ 5-ASA Duration: ______ ☐ Current Therapy ☐ Failed
☐ Azathioprine Duration: ______ ☐ Current Therapy ☐ Failed ☐ 6-MP Duration: ______ ☐ Current Therapy ☐ Failed

Failed Biologic(s) & Duration of Each: ______
Other medications patient is currently taking including OTC medications with dosage and directions (or fax Rx profile)______
Will patient stop taking the above medications before starting the new medication? ☐ Yes ☐ No If YES, what is the washout period? ______

Prescription

Medication	Strength & Directions	Quantity	Refill
Cimzia® ☐ Prefilled syringe (PFS) ☐ Lyophilized Powder (LYO)	☐ **Initial** dose of 400 mg SC at weeks 0, 2 and 4, then maintenance dosing (below) ☐ **Maintenance** dose of 400 mg SC every 4 weeks	☐ 1 month	
☐ Humira® Pen	☐ **Induction:** inject 160 mg (4 pens) SC on day 1, then 80 mg (2pens) on day 15, then maintenance dosing (below) ☐ **Maintenance**: inject 40 mg SC (1pen) SC every other week [OR] ☐ Other: ______	☐ 1 month	
Simponi ® ☐ SmartJect® ☐ Prefilled syringe	☐ **Induction:** inject 200 mg SC on first day, then 100 mg 14 days later, then maintenance dosing (below) ☐ **Maintenance**: inject 100 mg SC every four week [OR] ☐ Other: ______	☐ 1 month	
☐ Xifaxan® 550 mg Tablets	☐ Take one tablet by mouth twice a day **indicate previously failed therapy (Lactulose) ______	☐ 1 month	
☐ Uceris ® ER Tab 9 mg	☐ Take one tablet PO daily in the morning	☐ 1 month	
☐ Other:			

Need By Date: ______ Deliver to: ☐ Patient ☐ Physician's office ☐ 1st dose to Physician's office, remaining refills to patient home

Injection training needed? ☐ Yes ☐ No

Interchange is mandated unless practitioner writes the words **"BRAND MEDICALLY NECESSARY"**. ______

Physicians Signature (Required by Law): ______ Date: ______

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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