GASTROENTEROLOGY REFERRAL FORM

(Specialty Pharmacy A-S)

FLEXCARE SPECIALTY SERVICES

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 • Recent Clinicals & Labs • Patient Demographics • Tried/Failed Therapies • Neg TB Results

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's ds of small intestine, without complication
☐ K50.10 Crohn's ds of large intestine, without complication
☐ K50.80 Crohn's ds of both intestines, without complication
☐ K50.90 Crohn's ds unspecified, without complication
☐ K51.50 Left-sided UC, without complication
☐ K51.80 Other UC, without complication
☐ K51.90 UC unspecified, without complication
☐ Other:_____

PRIMARY MEDICATION ORDER

☐ New ☐ Refill	Ship by: ____/____/_____	Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

DRUG		DIRECTIONS & QUANTITY	REFILLS
Cimzia	☐ Pre-filled syringe ☐ Vials	☐ **INITIAL:** Inject 400mg (2 x 200mg) SubQ on day 0, 14, & 28 (Qty: 6) ☐ **MAINTENANCE:** Inject 400mg (2 x 200mg) SubQ every 4 weeks (Qty: 2)	
Dupixent	☐ Pen ☐ Pre-filled syringe	☐ Inject 300mg SubQ every week (Qty: 4)	
Humira	☐ PEN Starter Kit (80mg/0.8mL) ☐ SYRINGE Starter Kit (80mg/0.8mL) ☐ PEN (40mg/0.4mL) ☐ SYRINGE (40mg/0.4mL)	☐ **INITIAL:** Inject 160mg SubQ on day 1, 80mg on day 15 (Qty: 1 kit) ☐ **INITIAL:** Inject 80mg SubQ on days 1, 2, and 15 (Qty: 1 kit) ☐ **MAINTENANCE:** Inject 40mg SubQ every other week (Qty: 2)	
Rinvoq	☐ 45mg tablet	☐ **INITIAL:** Take 1 tablet (45mg) PO once daily (Qty: 28 with 1 refill)	
	☐ 15mg tablet ☐ 30mg tablet	☐ **MAINTENANCE:** Take 1 tablet (15mg) PO once daily (Qty: 30) ☐ **MAINTENANCE:** Take 1 tablet (30mg) PO once daily (Qty: 30)	
Simponi	☐ SmartJect Pen ☐ Pre-filled syringe	☐ **INITIAL:** Inject 200mg (2 x 100mg) SubQ at week 0, then 100mg (1 x 100mg) SubQ at week 2 (Qty: 3) ☐ **MAINTENANCE:** Inject 100mg SubQ every 4 weeks (Qty: 1)	

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:		Office Contact:
Practice Name:		Phone:
Address:		☐ Email:
City, State, Zip:		☐ Fax:
NPI:	License:	Tax ID:

Provider Signature (no stamps) _____ Date _____

PHONE: 866-205-4239 | FAX: 855-222-2514
EMAIL: referrals@flexcarespecialty.com | VISIT: flexcareinfusion.com/referrals

REVISED 06/23

GASTROENTEROLOGY REFERRAL FORM

(Specialty Pharmacy S-Z)

FLEXCARE SPECIALTY SERVICES

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 • Recent Clinicals & Labs • Patient Demographics • Tried/Failed Therapies • Neg TB Results

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's ds of small intestine, w/o complication
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☐ K51.80 Other UC, w/o complication
☐ K51.90 UC unspecified, w/o complication
☐ Other:_____

PRIMARY MEDICATION ORDER

☐ New ☐ Refill	Ship by: ____/____/_____	Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

DRUG		DIRECTIONS & QUANTITY	REFILLS
Skyrizi	☐ 600 mg vial ☐ 360 mg on-body device	☐ **INITIAL:** Infuse 600mg IV at weeks 0, 4, and 8 (to be administered in Infusion Clinic) ☐ **MAINTENANCE:** Inject 360mg SubQ at week 12 and every 8 weeks thereafter (Qty: 1)	
Stelara	☐ 130 mg vial ☐ 90 mg PFS syringe	☐ **INITIAL:** Infuse 260mg (<55kg) / 390mg (55-85kg) / 520mg (>85kg) IV once (to be administered in Infusion Clinic) ☐ **MAINTENANCE:** Inject 90mg SubQ every 8 weeks thereafter (Qty: 1)	
Xeljanz	☐ 10 mg tablet	☐ **INITIAL:** Take 1 tablet (10mg) PO twice daily (Qty: 60 with 1 refill)	
	☐ 5 mg tablet ☐ 10 mg tablet	☐ **MAINTENANCE:** Take 1 tablet (5mg) PO twice daily (Qty: 60) ☐ **MAINTENANCE:** Take 1 tablet (10mg) PO twice daily (Qty: 60)	
Xeljanz XR	☐ 22 mg tablet	☐ **INITIAL:** 1 tablet (22mg) PO once daily (Qty: 30 with 1 refill)	
	☐ 11 mg tablet ☐ 22 mg tablet	☐ **MAINTENANCE:** Take 1 tablet (11mg) PO once daily (Qty: 30) ☐ **MAINTENANCE:** Take 1 tablet (22mg) PO once daily (Qty: 30)	

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:		Office Contact:
Practice Name:		Phone:
Address:		☐ Email:
City, State, Zip:		☐ Fax:
NPI:	License:	Tax ID:

_____ _____

Provider Signature (no stamps) Date

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