Gastroenterology

Referral Form

Please fax completed form to:

Fax: 386-385-7871
Phone 386-456-3000
AccordSpecialty@gmail.com

Ship To/Site of Care:	☐ In Office	☐ At Home	☐ Other (list):

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescriber Name:			
Address:				Address:			
City, State, Zip:				City, State, Zip:			
Phone:		Weight (kg)		NPI AND License:			
Alt Phone:		Gender:		Office Contact:		Email:	
DOB:		SSN:		Px:		Fax:	

CLINICAL INFORMATION

Allergies:	☐ NKDA	☐ Allergies:	
Diagnosis:	ICD-10:	Condition:	Date of Diagnosis:

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
☐ **Cimzia**	☐ 200 mg SDV (2) ☐ 200 mg PFS	☐ INITIAL: Inject 400 mg SC at weeks 0, 2, and 4. ☐ MAINTENANCE: Inject 400 mg SC every 4 weeks	6	0
☐ **Entyvio**	☐ 300 mg/ 20 mL SDV	☐ INITIAL: Infuse 300 mg IV over 30 minutes at weeks 0, 2, and 6. ☐ MAINTENANCE: Infuse 300 mg IV over 30 minutes every _____ weeks ☐ INITIAL: Infuse 300 mg IV over 30 minutes at weeks 0 & 2, then switch to SC		0
	☐ 108 mg/0.68 mL ☐ Pen ☐ PFS	☐ MAINTENANCE: Inject 108 mg SC every 2 weeks beginning after at least 2 IV infusion doses.		
☐ **Infliximab (Avsola, Inflectra, Remicade, Renflexis)**	☐ 100 mg SDV	☐ INITIAL: Infuse 5 mg/kg IV over 2 hours at weeks 0, 2, and 6. ☐ MAINTENANCE: Infuse _____ mg/kg IV every _____ weeks		
	☐ Choice of brand per payer preference	☐ Do not auto-substitute. Brand Preferred: _____		
☐ **Zymfentra**	☐ 120 mg/mL Pen ☐ 120 mg/mL PFS	☐ Inject 120 mg SC every 2 weeks (starting at week 10 after IV induction therapy).		
☐ **Omvoh**	300 mg/ 15 mL SDV	☐ INITIAL, Crohns: Infuse 900 mg IV over at least 90 minutes at weeks 0, 4, & 8. ☐ INITIAL, UC: Infuse 300 mg IV over at least 30 minutes at weeks 0, 4 & 8.		0 0
☐ **Skyrizi**	☐ 600 mg/10 mL SDV	☐ INITIAL, Crohns: Infuse 600 mg IV over at least 1 hour at weeks 0, 4, & 8. ☐ INITIAL, UC: Infuse 1,200 mg IV over at least 2 hours at weeks 0, 4, & 8.		0 0
	☐ 180 mg/1.2 mL OBI 1	☐ MAINTENANCE: Inject 180 mg SC via on-body device at week 12 and every 8 weeks thereafter.		
	☐ 360 mg/2.4 mL OBI 1	☐ MAINTENANCE: Inject 360 mg SC via on-body device at week 12 and every 8 weeks thereafter.		
☐ **Tysabri**	300 mg/15 mL SDV	☐ Infuse 300 mg IV over 1 hour every 4 weeks.		
☐ **Tremfya**	☐ 200 mg/ 20 mL SDV	☐ INITIAL: Infuse 200 mg IV over at least 1 hour on weeks 0, 4, and 8		0
	☐ 100 mg/ mL Pen ☐ 100 mg/ mL PFS	☐ MAINTENANCE: Inject 100 mg SC every 8 weeks.		
	☐ 200 mg/ mL Pen ☐ 200 mg/ mL PFS	☐ INITIAL: Inject 400 mg SC on weeks 0, 4, & 8. ☐ MAINTENANCE: Inject 200 mg SC every 4 weeks.		
☐ **Other (list)**				

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

PRESCRIBER SIGNATURE

By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Accord Specialty to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed. I understand that I can revoke this designation by providing notice to Accord.

Prescriber's Signature: _____ Date: _____