GASTROENTEROLOGY REFERRAL FORM

Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555

Your CSP Rep: _______________ and Tel: _______________

PATIENT INFORMATION:	PHYSICIAN INFORMATION: Ship to: ☐Physician's Office ☐Patient's Home
Patient Name:	Physician Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Alternate Phone:	Phone: Fax:
Email:	Office Email:
Soc. Sec #:	Key Office Contact
Date of Birth: Sex: ☐ Male ☐ Female	State LIC # NPI # DEA#
Weight:_____ ☐ lbs ☐Kg Height:_____ ☐ ft ☐ cm BSA:______	

INSURANCE INFORMATION: ☐ DEMOGRAPHIC SHEET ☐UNIVERSAL CLAIM FORM ☐ INSURANCE CARDS (front + back)

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:

TB Test/Date:	**Prior Therapies:**
☐ **Patient is currently on therapy (Start date ___________________)**	

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: ____________________________

MEDICATIONS AND DIRECTIONS

PRESCRIPTIONS	DIRECTIONS	QUANTITY	FORMS	REFILL
☐ **Cimzia® (certolizumab)**	☐ Inject 400 mg subcut at weeks 0, 2 and 4	☐ 6 X 200 mg/mL	☐ PFS ☐ Vials	0
	☐ Inject 400 mg subcut every 4 weeks	☐ 2 X 200 mg/mL	☐ PFS ☐ Vials	_____
☐ **Entyvio® (vedolizumab)**	☐ Infuse IV 300mg weeks 0, 2 and 6	☐ 3 X 300 mg/mL	Vials	0
	☐ Infuse IV 300 mg every 8 weeks	☐ 1 X 300 mg/mL	Vials	_____
☐ **Humira® (adalimumab)**	☐ **Starter Dose:** Inject 160 mg subcut on day 1, then 80 mg on day 15	☐ 3 X 80 mg/0.8mL **CF**	Starter Kit Pens	0
		☐ 6 X 40 mg/0.8mL		
	☐ ____	☐ _____________	☐ _____________	
	☐ Inject 40 mg subcut on day 29 and every other week thereafter	☐ 2 X 40 mg/0.4mL **CF**	☐ PFS ☐ PENS	_____
		☐ 2 X40 mg/0.8mL		
☐ **Inflectra® (infliximab-dyyb)**	☐ Infuse IV 5 mg/kg or _____ mg week 0, 2 and 6	☐ 98 day supply (induction)	Vials	0
	☐ Infuse IV 5 mg/kg or _____ every 8 weeks	☐ 56 day supply	Vials	
☐ **Remicade® (infliximab)**	☐ Infuse IV 5 mg/kg or _____ mg week 0, 2 and 6	☐ 98 day supply (induction)	Vials	0
	☐ Infuse IV 5 mg/kg or _____ every 8 weeks	☐ 56 day supply	Vials	
☐ **Simponi® (golimumab)**	☐ Inject 200 mg subcut at week 0, then 100 mg at week 2	☐ 3 X 100 mg/mL	☐ SmartJect® Autoinjector ☐ PFS	0
	☐ Inject 100 mg subcut every 4 weeks	☐ 1 X 100 mg/mL	☐ SmartJect® Autoinjector ☐ PFS	_____
☐ **Skyrizi**	☐ Inject 600 mg IV at weeks 0, 4, and 8	☐ 3x 600 mg/10 mL		
	☐ Inject 180 mg subcut at week 12 and every 8 weeks thereafter	☐ 1 x 180 mg/1.2 mL		
	☐ Inject 360 mg subcut at week 12 and every 8 weeks thereafter	☐ 1 x 360 mg/2.4 mL		
☐ **Stelera® (ustekinumab)**	☐ Infuse 260 mg intravenously over no less than one hour (≤ 55kg)	☐ 2 X 130 mg/26 mL	Vials	0
	☐ Infuse 390 mg intravenously over no less than one hour (> 55kg to <85)	☐ 3 X 130 mg/26mL		
	☐ Infuse 520 mg intravenously over no less than one hour (>85kg)	☐ 4 X 130 mg/26mL		
	☐ Inject 90 mg subcut 8 weeks following initial intravenous dose, then every 8 weeks thereafter	☐ 1 X 90 mg/mL	PFS	_____
	☐ Date of last infusion: ___________________			
☐ **Xeljianz® (tofacitinib)**	☐ Take 10 mg by mouth twice daily for 8 weeks	☐ 60 X 10 mg	Tablets	1
	☐ Take 10 mg by mouth twice daily	☐ 60 X 10 mg	Tablets	_____
	☐ Take 5 mg by mouth twice daily	☐ 60 X mg		
	☐ ____________________________________			
☐ **Xeljanz® ER (tofacitinib)**	☐ 22 mg once daily for 8 weeks	☐ 60 x 11 mg ☐ RF:1		
	☐ 22 mg once daily	☐ 60 x 11 mg		
	☐ MD: 11 mg once daily	☐ 30 x 11 mg		
☐ **Xifaxan® (rifaximin)**	☐ Take 1 tablet by mouth two times a day	☐ 60 X 550mg	Tablets	_____
	☐ Take 1 tablet by mouth three times a day	☐ 42 X 550 mg		
	☐ ____________________________________	☐__________		

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

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

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED _______ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
x		

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