US Bioservices
AmerisourceBergen

Gastroenterology Referral Form

Phone: (888) 518-7246
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work / Mobile Phone: _____

First Name: _____ Home Address: _____

S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____

Guardian / Caregiver: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____

Subscriber Name: _____ Policy #: _____ BIN / PCN: _____

Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA License #: _____ NPI #: _____ DEA #: _____

Practice Name: _____ Phone: _____ Fax: _____

Address: _____ Office Contact: _____ Phone: _____

City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: _____ Secondary ICD-10: _____ Tested Negative for TB? ☐ Yes ☐ No

Allergies: _____ ☐ Sulfasalazine ☐ Oral Corticosteroids ☐ Asathioprine

Meds Tried / Failed: _____ ☐ 6-mercaptopurine ☐ Topical (rectal) corticosteroids ☐ 5-ASA

Congestive Heart Failure? ☐ Yes ☐ No Active Infection? ☐ Yes ☐ No ☐ Biologics: _____

5. Prescription Information

Medication	Dose / Strength	Directions	Dispense	Refills
CIMZIA®	☐ 200 mg Starter Kit	☐ Initial dose: Inject 400 mg SC once weekly at weeks 0, 2 and 4	1	0
	☐ 200 mg LYO SDV Kit ☐ 200 mg PFS Kit	☐ Maintenance dose: Inject 400 mg SC q4weeks	2	
ENTYVIO®	☐ 300 mg/20 mL LYO SDV	☐ Initial Dose: Infuse 300mg IV over 30 minutes at weeks 0, 2 and 6	3	0
		☐ Infuse 300 mg IV over 30 minutes q8weeks	1	
HUMIRA®	Crohn's / UC Starter Pack: ☐ 6x40 mg/0.8 mL Pens	☐ Inject 160 mg SC on day 1, then inject 80 mg on day 15, then inject 40 mg q2weeks ☐ Inject 80 mg SC on day 1, 2 and 15, then inject 40 mg q2weeks	1	0
	Pediatric Crohn's Disease Starter Pack: ☐ 6x40 mg/0.8 mL PFS ☐ 1x80 mg/0.8 mL and ☐ 3x80 mg/0.8 mL PFS ☐ 1x40 mg/0.8 mL PFS ☐ 3x40 mg/0.8 mL PFS	☐ 17 kg (37 lb) to <40 kg (88 lb): Inject 80 mg SC on day 1, then inject 40 mg SC on day 15, then on day 29 transition to maintenance dosing ☐ ≥40 kg (88 lb): Inject 160 mg SC, then inject 80 mg SC on day 15, then on day 29 transition to maintenance dosing		
	☐ 20 mg/0.2 mL PFS ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.8 mL Pen	☐ Inject 20 mg SC QOW ☐ Inject 40 mg SC QOW		
SIMPONI®	☐ 100 mg/mL PFS ☐ 100 mg/mL SmartJect® Autoinjector	☐ Initial dose: Inject 200 mg SC at week 0, then 100 mg SC at week 2, then 100 mg SC q4weeks	3	0
		☐ Maintenance dose: Inject 100 mg SC q4weeks	1	
STELARA®	☐ 130 mg/25 mL SDV	☐ ≤55 kg (121 lb): Infuse 260 mg (2 vials) over at least 1 hour ☐ >55 kg to 85 kg (121 lb to 187 lb): Infuse 390 mg (3 vials) over at least 1 hour ☐ >85 kg (187 lb): Infuse 520 mg (4 vials) over at least 1 hour		0
	☐ 90 mg/mL PFS	☐ Maintenance Dose: Inject 90 mg SC 8 weeks after initial IV dose, then q8weeks thereafter	1	
XELJANZ®	☐ 5 mg tabs ☐ 10 mg tabs	☐ Initial dose: Take 10 mg PO BID for 8 weeks		
		☐ Maintenance dose: Take 5 mg PO BID ☐ Maintenance dose: Take 10 mg PO BID		
XIFAXAN®	☐ Hepatic Encephalopathy: 550 mg tabs	• Take 550 mg PO BID	60 Tablets	
	☐ Irritable Bowel Syndrome w/Diarrhea: 550 mg tabs	• Take 550 mg PO TID for 14 days	42 Tablets	0

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date ____ / ____ / ____

Account Manager

_____

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____