Fax: 614-929-7199 | Phone: 614-929-3349 | Email: intake@infuseoneohio.com

INFUSE ONE OHIO

☐ Dublin, OH
☐ Lancaster, OH

Gastroenterology Referral Form

Please Attach Copy of Insurance Cards (Front & Back)

Last Name, First Name _____ Date of Birth: _____ Gender: ☐ M ☐ F ☐ Other

Address: _____ City, State, Zip _____

Phone _____

Referring Practice: _____

Practice Address: _____ City, State, Zip _____

Prescriber Name: _____ Prescriber NPI: _____

Nurse/Key Contact: _____ Phone: _____

Fax: _____ Email: _____

Insurance Information

Insurance Plan: _____ Insurance Plan: _____

Policy#: _____ Plan ID: _____ Policy#: _____ Plan ID: _____

Diagnosis & Clinical Information

☐ Crohn's Disease Diagnosis Code: _____
☐ Ulcerative Colitis Diagnosis Code: _____
☐ Other _____
Currently received and/or prior filed therapies: _____
Length of treatment: _____
Reason for discontinuation: _____

Please attached Clinical/Progress Notes, Labs, Tests, Supporting Primary Diagnosis**

TB/PPD Test: ☐ Positive ☐ Negative Date: _____
☐ Allergies _____
☐ NKDA
Height: _____ Weight: _____
Site of Care: ☐ Home ☐ AIC ☐ Other _____

Prescription Information

MEDICATION	DOSE/STRENGTH	DIRECTIONS	REFILLS
☐ Entyvio (vedolizumab)	☐ 300mg vial	☐ INITIAL: Infuse 300mg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENANCE: Infuse 300mg IV every _____ weeks	
☐ Infliximab ☐ Remicade ☐ Renflexis ☐ Inflectra	☐ 100mg vial	☐ INITIAL: Infuse_____ mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENANCE: Infuse _____ mg/kg IV every _____ weeks ☐ Other _____ ☐ Pharmacist will round to the nearest 100mg ☐ Give exact dose (do NOT round)	
☐ Stelara (ustekinumab)	☐ 130 mg / 26ml vial ☐ 90mg (2x 45mg vials)	☐ INITIAL: Weight based dosing, infuse IV ☐ 55kg or less: 260mg (2 vials) ☐ 55kg to 85kg: 390mg (3 vials) ☐ Greater than 85kg: 520 mg (4 vials) ☐ MAINTENANCE: Inject 90mg SQ 8 weeks after initial dose, then every 8 weeks thereafter	
☐ Skyrizi (risankizumab)	☐ 600mg / 10ml vial ☐ 1200mg / 20ml	☐ INITIAL: Infuse 600mg/10mL or 1200mg/20mL IV at week 0, 4, and 8 ☐ MAINTENANCE: Inject SQ via injector at week 12, then every 8 weeks thereafter	

Pre-medication & other medications
* Infusion supplies as per protocol
* Anaphylaxis kit as per protocol

☐ Acetaminophen mg PO prior to infusion
☐ Diphenhydramine mg ☐ PO ☐ IV
☐ 250ml 0.9%NaCl for hydration
☐ Other

Flush Protocol
* NaCl 0.9% 10ml
* Before & after infusion

I authorize Infuse One Ohio and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Infuse One Ohio..

Physician Signature: _____

Date: _____

Provider Phone Line: (614) 929-3349

Please be sure to attach all of the following:

- Patient demographics
- Patient medical insurance card copied front and back
- Patient pharmacy card copied front and back (if they have one)
- Most recent chart notes, diagnostic testings, and labs.
- Proof of patient being concurrently treated with any other biologics