Gastroenterology Medication Referral Form

TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

Date: _____

Patient Name: _____

Date of Birth: _____

INFORMATION

Ship to:	Injection training provided by:
☐ Patient	☐ Prescriber's office
☐ Physician/clinic	☐ Specialty Pharmacy
☐ 1st dose to Physician/clinic, remaining refills to patient	☐ Manufacturer
	☐ Other: _____

DIAGNOSIS

Description / ICD-10 Code

☐ A04.7 Enterocolitis due to Clostridium difficile
☐ K51._____ Ulcerative colitis
☐ K72.9 Hepatic failure, unspecified (Hepatic Encephalopathy)
☐ K50._____ Crohn's disease
☐ K58.0 Irritable Bowel Syndrome w/ Diarrhea
☐ Other: _____

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

☐ Patient demographics ☐ Medical card (front and back) ☐ Prescription card (front and back) ☐ Clinic notes and labs (including Hepatitis B screening)

☐ Last 4 Digits of Social:_____ TB Test Completed: ☐ Yes ☐ No Date of negative test: _____/_____/_____ (Please send copy of results)

Patient Weight: _____ Kg/lbs Height: _____ Inches/CM Allergies: _____

Currently Receiving and/or Prior Failed Therapies:	☐ NSAIDS ☐ Methotrexate ☐ Sulfasalazine ☐ 5-ASA ☐ Azathioprine ☐ Corticosteroids ☐ Mercaptopurine ☐ Biologics:_____ ☐ Other: _____ Length of Treatment: _____ Reason for Discontinuing or Adding Supplemental Tx: _____	Contraindicated Medications: Reason:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia	☐ 200mg/ml PFS Starter Kit	Induction: Inject 400mg (two 200mg injections) SQ at weeks 0, 2, and 4, then maintenance dose	1 box (six 200mg PFS)	0
	☐ 200mg/ml PFS	Maintenance: Inject 400mg (two 200mg injections) SQ every 4 weeks	2	
	☐ 200mg LYO Powder Vial			
☐ Dificid	☐ 200mg tablet	Take 1 tablet by mouth twice daily for 10 days	20	0
☐ Humira	☐ 80mg/0.8ml CF Pen Starter Kit for Crohn's/UC	Induction: Inject 160mg SQ on Day 1, 80mg on Day 15, then maintenance dose	1 box (three 80mg Pens)	0
	☐ 40mg/0.4ml CF Pens	Maintenance: Inject 40mg SQ every other week	2	
	☐ 40mg/0.4ml CF PFS	Other:		
☐ Simponi	☐ 100mg/ml SmartJect Autoinjector	Induction: Inject 200mg SQ at week 0, then 100mg at week 2, then maintenance dose	3	
	☐ 100mg/ml PFS	Maintenance: Inject 100mg SQ every 4 weeks	1	
☐ Xeljanz	☐ 10mg tablet	Induction: Take 10mg by mouth twice daily for 8 weeks		1
	☐ 5mg tablet	Maintenance: Take 5mg by mouth twice daily		
☐ Xeljanz XR	☐ 22mg tablet	Induction: Take 22mg by mouth once daily for 8 weeks		1
	☐ 11mg tablet	Maintenance: Take 11mg by mouth once daily		
		Other:		
☐ Xifaxan	☐ 550mg tablet	Take 1 tablet by mouth twice daily		
		Take 1 tablet by mouth three times daily for 14 days	42	
		Other:		

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone: _____ Physician's NPI#: _____ Physician's Fax# : _____ Physician's Address: _____

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

V 5.19.21