Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Gastroenterology Referral Form

1204 SE 28th St, Suite 2
Bentonville, AR 72712
Phone: 844-414-5805
Fax: 855-422-2400

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	
Sex: ❑ Male ❑Female **Weight** lbs/kg Height	
Allergies:	

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis
❑K50. _____ Crohn's Disease ❑K51. _____ Ulcerative Colitis
❑K20.0 Eosinophilic esophagitis ❑Other _________________
Date of Diagnosis:______________________________

Prior and Current Treatment *(please attach list if necessary)*
Is the patient currently being treated or previously been treated for diagnosis indicated? ❑Yes ❑No
If yes, name the product(s), approximate date range(s) and response/outcome, listing current therapy first if applicable.
Product:_________________________ Date Range:_________ to _________ Response/outcome:________________
Product:_________________________ Date Range:_________ to _________ Response/outcome:________________

PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
Cimzia® *(Crohn's)*	❑ Starter Kit 200mg PFS ❑ 200mg/mL PFS	Initial: ❑ Inject 400mg SC at weeks 0, 2, & 4. Maintenance: ❑ Inject 200mg SC every other week. ❑ Inject 400mg SC every 4 weeks.	❑ 6 x 200mg/mL Starter Kit ❑ 2 x 200mg/mL injections	0 _____
Dupixent® *(EOE)*	❑ 300mg/2mL Pen ❑ 300mg/2mL PFS	❑ Inject 300mg SC once weekly.	❑ 4 x 300mg/2mL injections	
Humira® Citrate Free *(Crohn's/UC)* **Humira®** *(Crohn's/UC)*	❑ Crohn's/UC Starter Pack ***citrate free*** ❑ Crohn's/UC Starter Pack ❑ 40mg/0.4mL Pen ***citrate free*** ❑ 40mg/0.4mL PFS ***citrate free*** ❑ 40mg/0.8mL Pen ❑ 40mg/0.8mL PFS	Loading: ❑ Inject 160mg SC for first dose (Day 1). Then inject 80mg SC two weeks after first dose (Day 15). Maintenance: ❑ Inject 40mg SC on day 29 and every other week thereafter.	❑ 3 x 80mg/0.8mL **CF** Pens ❑ 6 x 40mg/0.8mL Pens ❑ 2 injections	0 _____
Rinvoq® *(UC)*	❑ 45mg ER tablet ❑ 15mg ER tablet ❑ 30mg ER tablet	Induction: ❑ Take 1 tablet by mouth once daily for 8 weeks. Maintenance: ❑ Take 1 tablet by mouth once daily.	❑ 28 tablets ❑ 30 tablets	1 _____
Simponi® *(UC)*	❑ 100mg/mL PFS ❑ 100mg/mL SmartJect® Autoinjector	Induction: ❑ Inject 200mg SC at week 0, then inject 100mg SC at week 2. Maintenance: ❑ Inject 100mg SC every 4 weeks.	❑ 3 x 100mg/mL injections ❑ 1 x 100mg/mL injection	0 _____
Skyrizi® *(Crohn's)*	❑ 180mg/1.2mL Prefilled Cartridge w/On Body Injector (OBI) ❑ 360mg/2.4mL Prefilled Cartridge w/On Body Injector (OBI)	❑ Inject 180mg SC using OBI every 8 weeks starting on week 12. ❑ Inject 360mg SC using OBI every 8 weeks starting on week 12. Completed or scheduled IV loading dose dates: Week 0:___________ Week 4:____________ Week 8:____________	❑ 1 kit ❑ 1 kit	_____ _____
Stelara® *(Crohn's/UC)*	❑ 90mg/mL PFS	❑ Inject 90mg SC 8 weeks following loading IV dose, then every 8 weeks thereafter. IV loading dose administration date:__________________	❑ 1 x 90mg/mL injection	_____
Xeljanz® *(UC)*	❑ 10mg IR tablet ❑ 5mg IR tablet	❑ Take 10mg (1 tablet) by mouth twice daily for induction. ❑ Take 5mg (1 tablet) by mouth twice daily for maintenance.	❑ 60 tablets ❑ 60 tablets	
Xeljanz®XR *(UC)*	❑ 22mg XR tablet ❑ 11mg XR tablet	❑ Take 22mg (1 tablet) by mouth once daily for induction. ❑ Take 11mg (1 tablet) by mouth once daily for maintenance.	❑ 30 tablets ❑ 30 tablets	
Other	❑ __________________	❑ ____	❑ ____________	

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.*

Date: _________________________ ____ ____

DISPENSE AS WRITTEN **MAY SUBSTITUTE**