QueensExpressPharmacy
Your Specialty and IV-Compounding Pharmacy

34-54 Junction Blvd
Jackson Heights, NY 11372
Phone: (718) 565-1009
Fax: (718) 565-1004
www.QEPHEALTH.com

GASTROENTEROLOGY REFERRAL FORM

Fax prescription to: 718-565-1004

Faxed prescriptions can only be accepted from prescribing practitioners

Date Needed By _____ Ship to: ☐Patient ☐Office ☐Other: _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ SS# _____ DOB _____

☐Male ☐Female Height_____ Weight _____ Age _____

Allergies _____ ☐NKDA

INSURANCE INFORMATION

Please attach front and back of all insurance and prescription drug cards

PRESCRIBER INFORMATION

Name _____

NPI _____ State License# _____

Group/Hospital _____

Address _____

City, State, Zip _____

Main Phone _____ Fax _____

Contact Person _____ Phone _____

CLINICAL EVALUATION

DIAGNOSIS

☐ K50.90 Chron's Disease
☐ K51.90 Ulcerative Diseases
☐ B19.10 Hepatitis B
☐ Other _____
DX code _____
Diagnosis Date _____

Has patient been treated previously for this condition?
☐Yes ☐No

PREVIOUS TREATMENTS

☐NSAIDS: Duration/Comments _____
☐MTX: Duration/Comments _____
☐Biologics:Duration/Comments _____
☐Sulfasalazine: Duration/Comments _____
☐5-ASA (5-Aminosalicylates:) Duration/Comments _____
☐Azathioprine: Duration/Comments _____
☐Corticosteroid: Duration/Comments _____
☐6-MP (6-Mercaptopurine):Duration/Comments _____
Is patient currently on any therapy? ☐Yes ☐No
If yes, list medications _____

LABS

Has TB test been performed? ☐Yes *(If yes, please attach results)* ☐No
Lab Date _____ TB Results _____
Comments _____

HISTORY

Enterocutaneous/Rectovaginal Fistulas? ☐Yes ☐No
Has patient been diagnosed with heart failure? ☐Yes ☐No
Has patient been diagnosed with lymphoma? ☐Yes ☐No
Does patient have serious/active infection? ☐Yes ☐No
Is patient at risk for Hepatitis B infection? ☐Yes ☐No
If yes, has Hepatitis B been ruled out or treatment initiated? ☐Yes ☐No

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
☐ **CIMZIA (certolizumab pegol)** ☐ Starter Kit ☐ 200mg prefilled syringe ☐ 200mg vial	☐ Induction: Inject 400mg subcutaneously at weeks 0, 2, and 4 ☐ Maintenance: Inject 400mg subcutaneously every 4 weeks	☐ 4-Weeks supply	
☐ **ENTYVIO (vedolizumab)**	☐ Induction: Infuse IV 300mg, over 30 minutes at weeks 0, 2, and 6 ☐ Maintenance does: Infuse IV 300mg, over 30 minutes every 8 weeks	☐ Enter quantity _____	
☐ **HUMIRA (adalimumab)** ☐ 40mg/0.8ml pen ☐ 40mg/0.8ml prefilled syringe ☐ Chron's/UC Starter Kit	☐ Induction: Inject 160mg (4 pens) subcutaneously on day 1, then 80mg (2 pens) on day 15 ☐ Maintenance: Inject 40mg (1 injection) subcutaneously every other week ☐ Other _____	☐ Enter quantity _____	
☐ **REMICADE (infliximab)** ☐ 100mg vial	☐ Induction: IV at 5mg/kg (Dose = _____ mg) at weeks 0, 2, and 6 ☐ Maintenance: IV at 5mg/kg (Dose = _____ mg) every 8 weeks ☐ Other _____	☐ Enter quantity _____	
☐ **SIMPONI (golimumab)** ☐ 100mg SmartJect ☐ 100mg prefilled syringe	☐ Induction: Inject 200mg subcutaneously at week 0, then 100mg at week 2 ☐ Maintenance: Inject 100mg subcutaneously every 4 weeks	☐ Enter quantity _____	
☐ **VIBERZI (eluxadoline)** ☐ 100mg tablets ☐ 75mg tablets	☐ IBS with diarrhea: 100mg twice a day ☐ Patients WITHOUT gallbladder: 75mg twice a day	☐ Enter quantity _____	
☐ **XIFAXAN (rifaximin)** ☐ 550mg tablets	☐ Hepatic Encephelopathy: 550mg twice a day ☐ IBS with diarrhea: Inject 550mg 3 times a day	☐ Enter quantity _____	
☐ **OTHER** _____	☐ Directions _____	☐ Enter quantity _____	
HEPATITIS B TREATMENTS ☐ Baraclude 1mg ☐ Baraclude 0.5mg ☐ Tyzeka 600mg ☐ Epivir HBV 100mg ☐ Hepsera 10mg ☐ Other_____	☐ Directions _____ _____	☐ Enter quantity _____	

By signing this form and utilizing our services, you are authorizing Queens Express Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature _____ ☐DAW Date _____