ADVANCED PHARMACY & RESPIRATORY CARE SOLUTIONS

Today's Date _____

Date Needed _____

GASTROENTEROLOGY REFERRAL FORM

26611 Cabot Road Suite B | Laguna Hills CA 92653
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NPI# 1922103142 NABP# 0547185
info@aps-rx.net APS-rx.net

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ APS Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____

Primary Insurance _____ Member ID _____
RxBIN _____ Rx PCN _____ Rx Grp _____
Member Services Number _____ Provider Services Number _____

ICD-10 Diagnosis Code: ☐ K50.00 Crohn's Disease ☐ B18.2 Chronic Hep C ☐ K58.0 IBS-D ☐ K51.0 Ulcerative Colitis ☐ Other_____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop taking the medication(s) before starting the new medication? ☐ Yes ☐ No
If yes, how long should patient wait before starting the new medication? _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
PPD (TB Test) ☐ Yes ☐ No Date_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **HUMIRA® PEN CROHN'S DISEASE STARTER PKG** ☐ **HUMIRA® Citrate-Free PEN CROHN'S DISEASE STARTER PKG**
Starter Dose: ☐ Inject 160 mg SQ on Day 1, then inject 80mg SQ on Day 15 QTY: 4 week supply Refills: _____
☐ Alt. Dosage _____ QTY: _____ Refills: _____

HUMIRA® MAINTENANCE THERAPY
☐ **HUMIRA® PEN** 40 mg/0.8 mL ☐ **HUMIRA® PFS** 40 mg/0.8 mL ☐ **HUMIRA® Citrate-Free PEN** 40 mg/0.4 mL ☐ **HUMIRA® Citrate-Free PFS** 40 mg/0.4 mL
☐ Maintenance dose: Inject 40 mg SQ every other week starting on Day 29 QTY: 2 Refills: _____
☐ Alt. Dosage _____ QTY: 28 days supply Refills: _____

SIMPONI™ ☐ **SmartJect™ Autoinjector** 50mg/0.5mL ☐ **PFS** 50mg/0.5mL ☐ **SmartJect™ Autoinjector** 100mg/1mL
☐ Starter dose: 200mg SC at week 0, then 100mg SC at week 2 QTY: _____
☐ Maintenance: ☐ 100mg SC every 4 weeks | QTY: 1 ☐ 50mg SC every 4 weeks | QTY: 1 Refills: _____
☐ Other: _____ QTY: _____ Refills: _____

MAVYRET™ ☐ 100 mg glecaprevir / 40 mg pibrentasvir tablet
SIG: Take 3 tablets orally once daily with food for: ☐ 8 weeks (No Cirrhosis) or ☐ 12 weeks (Cirrhosis)
Total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg QTY 84 Refill _____

VOSEVI™ ☐ 400mg sofosbuvir/ 100mg velpatasvir/ 100mg voxilaprevir tablet
SIG: ☐ Take 1 tablet by mouth daily with food for 12 weeks QTY 28 Refill _____
☐ Other: _____ QTY _____ Refill _____

EPCLUSA® ☐ Sofosbuvir 400mg/ Velpatasvir 100mg tablet
SIG: Take 1 tablet by mouth daily QTY 28 Refill _____

VIEKIRA XR™ QTY 84 Refill _____
☐ Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg
Directions: Take 3 tablets PO QAM with meal for ☐ 12 weeks ☐ 24 weeks

VIEKIRA PAK® QTY 112 Refill _____
☐ Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75mg/50mg tablets (pink) and Dasabuvir 250mg tablet (beige)
Directions: Take 2 pink tablets PO once daily (AM) with food and one beige tablet PO twice daily (AM and PM) with food.

ZEPATIER™ ☐ Grazoprevir 100mg/ Elbasvir 50mg tablet
SIG: Take one tablet by mouth daily QTY 28 Refill _____

ENTYVIO® ☐ 300mg
SIG: ☐ Starter: Infuse 300mg IV at weeks 0, 2, and 6, then maintenance QTY 3 Refill _____
☐ Maintenance: Infuse 300mg IV every 8 weeks QTY 1 Refill _____

DIFICID® ☐ 200mg TABLET
SIG: Take one tablet orally twice daily for 10 days with or without food QTY 20 Refill ___

VIBERZI® ☐ 100MG ☐ 75MG
SIG: Take 1 tablet by mouth twice daily with food QTY 60 Refill _____

XELJANZ® (Tofacitinib Citrate) ☐ 5mg tablet ☐ 10mg tablet
SIG: ☐ Take 1 5mg tablet by mouth twice daily QTY 60 Refill _____
☐ Take 1 10mg tablet by mouth twice daily QTY 60 Refill _____

☐ **DONNATAL®** ☐ 16.2mg TABLET
☐ **ZOFRAN®** ☐ 4mg ☐ 8mg
☐ **RELISTOR®** ☐ 8mg PFS ☐ 12mg PFS ☐ 150mg TABLET
☐ **PROCRIT®** vial Includes 25G 1/2" syringes and alcohol pads w/ all dispenses
☐ **XIFAXAN®** ☐ 200mg ☐ 550mg
☐ 1 200mg TAB PO TID x 3 Days QTY 9 Refill _____
☐ 1 550mg TAB PO BID QTY 60 Refill _____
☐ 1 550mg Tab PO TID x 14 Days QTY 42 Refill _____
SIG_____ QTY_____ Refill_____

DAKLINZA™ ☐ 30mg OR ☐ 60mg / ☐ 400mg SOVALDI
SIG: take 1 tablet each daily QTY 28 Refill _____ GT3 ONLY

TECHNIVIE™ ☐ Paritaprevir/Ritonavir (75/50mg) and Ombitasvir (12.5mg)
SIG: two tablets QAM with meal QTY 1 week supply Refill _____ GT4 ONLY

RIBAVIRIN® ☐ 200mg Caps **OR** ☐ 200mg Tabs
SIG: ☐ ≤75kg: 400mg in the AM and 600mg in the PM
☐ >75kg: 600mg in the AM and 600mg in the PM
☐ Other: _____ QTY: _____ Refill _____

HARVONI® ☐ Ledipasvir 90mg / Sofosbuvir 400mg
SIG: Take 1 tablet by mouth daily QTY 28 Refill _____

SOVALDI® (sofosbuvir) ☐ 400MG TABLET QTY 28 Refill _____
SIG: Take 1 tablet by mouth daily for:
☐ 12 weeks w/ Ribavirin and peginterferon (Genotype 1 or 4)
☐ 12 weeks with Ribavirin (Genotype 2)
☐ 24 weeks with Ribavirin (Genotype 3)

STELARA® ☐ 130 mg/26 mL vial *Patient Weight (kg):* _____
☐ 45mg PFS ☐ 45mg SD Vial ☐ 90mg PFS
SIG: ☐ Starter Dose: Infuse ____mg/mL on week 0 then,
☐ Maint. Dose: Inject 90mg SQ 8 wks after the initial IV dose, then every 8 wks. QTY_____ Refill_____

Weight of Patient (Kg)	Recommended Dosage	Vials
≤ 55 kg or less	260 mg	2
55 kg to 85 kg	390 mg	3
≥ 85 kg	520 mg	4

CIMZIA® ☐ 200mg/1ml PFS ☐ PFS Starter Kit QTY 4 week supply Refill _____
SIG: ☐ Initial Dose: Inject 400mg SQ on day 1, at week 2 & at week 4
☐ Maintenance Dose: Inject 400mg SQ every 4 weeks

☐ **BARACLUDE®** ☐ 0.5mg ☐ 1.0mg ☐ **EPIVIR® HBV** 100MG
☐ **HEPSERA®** 10MG ☐ **VEMLIDY®** 25MG ☐ **VIREAD®** 300MG
SIG_____ QTY_____ Refill_____

☐ **OTHER**_____
SIG_____ QTY_____ Refill_____

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES "D A W" IN THIS BOX ☐

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.