GREENHILL
— INFUSION SOLUTIONS —

GI THERAPY REFERRAL FORM

Please fax completed referral form to Greenhill:
(302) 486-3400

Please contact office for questions:
(302) 356-0506

PATIENT DEMOGRAPHICS:

PATIENT NAME:

DATE OF REFERRAL:

SOCIAL SECURITY NUMBER:

DATE OF BIRTH:

PREFERRED CONTACT #:

SECONDARY CONTACT #:

ADDRESS:

CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

- ☐ K50.0 - Crohn's Disease of the small intestine
- ☐ K50.1 - Crohn's Disease of the large intestine
- ☐ K50.8 - Crohn's Disease of small & large intestine
- ☐ K50.9 - Crohn's disease, unscpeified
- ☐ Other ICD-10 code & description: _____
- ☐ K51.0 - Ulcerative pancolitis
- ☐ K51.2 - Ulcerative (chronic) proctitis
- ☐ K51.3 - Ulcerative (chronic) rectosigmoiditis
- ☐ K51.5 - Left sided colitis
- ☐ K51.8 - Other ulcerative colitis

PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

PRIOR THERAPY (if any):	APPROX START DATE:	APPROX. END DATE:	REASON FOR DISCONTINUATION:

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA

HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg

GENDER: ☐ F ☐ M

FIRST DOSE: ☐ Y ☐ N

DATE OF LAST INFUSION:

NEXT DOSE DUE BY:

ACCESS/LINE TYPE: ☐ PIV ☐ PORT ☐ PICC ☐ MIDLINE

OTHER:

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

- ☐ 1. INSURANCE CARD (Front & Back)
- ☐ 2. PATIENT DEMOGRAPHICS
- ☐ 3. MOST RECENT LABS
- ☐ 4. H & P
- ☐ 5. NEGATIVE TB TEST RESULTS
- ☐ 6. NEGATIVE HEPATITIS B TEST RESULTS

TESTING RESULTS: If prescribing, Cimzia, Humira, Remicade, Stelara

TB SCREENING DATE: _____

HEP B SCREENING DATE: _____

MEDICATION WASTE:

Authorized to round up to nearest vial size?

☐ YES ☐ NO

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

- ☐ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER GREENHILL INFUSION POLICY AND PROCEDURE
- ☐ OTHER: (please fax other reaction orders if checking this box)

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior every infusion	PRN
Acetaminophen ____ mg PO	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Diphenhydramine ____ mg PO	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Diphenhydramine ____ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 minutes.	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Methylprednisolone ____ mg IV push over 5 minutes.	☐	
Methylprednisolone 100mg IV	☐	

GREENHILL HEALTH initiative

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MEDICATION SELECTION:

CIMZIA (certolizumab pegol)	**INDUCTION DOSE:** ☐ 400 MG SC on WEEKS 0, 2, & 4 **MAINTENANCE DOSE:** ☐ 400 MG SC EVERY 4 WEEKS REFILLS:_____
Entyvio vedolizumab	**INDUCTION DOSE:** ☐ 300 MG IV WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 300 MG IV EVERY 8 WEEKS **ALTERNATIVE DOSE:** ☐ _____ REFILLS:_____
HUMIRA adalimumab	**INDUCTION DOSE:** ☐ 160 MG SC then 80 MG SC TWO WEEKS LATER **MAINTENANCE DOSE:** ☐ 40 MG SC QOW, BEGINNING DAY 29 **ALTERNATIVE DOSE:** ☐ _____ REFILLS:_____
Inflectra infliximab	**INDUCTION DOSE:** ☐ 5 MG/KG IV on WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 5 MG/KG OR ☐ 10 MG/KG IV EVERY 8 WEEKS **ALTERNATIVE DOSE:** ☐ _____ MG/KG IV EVERY ____ WEEKS REFILLS:_____
Remicade INFLIXIMAB	**INDUCTION DOSE:** ☐ 5 MG/KG IV on WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 5 MG/KG OR ☐ 10 MG/KG IV EVERY 8 WEEKS **ALTERNATIVE DOSE:** ☐ _____ MG/KG IV EVERY ____ WEEKS REFILLS:_____
Simponi golimumab	**INDUCTION DOSE:** ☐ 200 MG SC, THEN 100MG SC AT WEEK 2 **MAINTENANCE DOSE:** ☐ 100 MG SC EVER 4 WEEKS REFILLS:_____
Simponi ARIA golimumab for infusion	☐ 2 MG/KG on WEEKS 0, 4, & EVERY 8 WEEKS THEREAFTER REFILLS:_____
Stelara (ustekinumab)	**LOADING DOSE:** ☐ 45 MG SC THEN 45 MG SC 4 WEEKS LATER or ☐ 90 MG SC THEN 90 MG SC 4 WEEKS LATER **MAINTENANCE DOSE:** ☐ 45 MG SC EVERY 12 WEEKS or ☐ 90 MG SC EVERY 12 WEEKS REFILLS:_____
XELJANZ (tofacitinib)	**IR:** ☐ 5 MG PO BID ☐ 10 MG PO BID x #60 **XR:** ☐ 22 MG PO DAILY ☐ 11 MG PO DAILY x #30 REFILLS:_____
IMMUNOGLOBULIN THERAPY	**BRAND:** ☐ NO PREFERENCE ☐ GAMUNEX ☐ OCTAGAM ☐ _____ **DOSING:** ☐ _____ GRAMS IV ☐ _____ GRAMS SC **DIRECTIONS:** _____ REFILLS:_____
RITUXIMAB	**BRAND:** ☐ NO PREFERENCE ☐ RITUXAN ☐ TRUXIMA ☐ MABTHERA ☐ _____ **MAINTENANCE DOSE:** ☐ 2000 MG IV EVERY 6 MONTHS THERAFTER REFILLS:_____

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: