REALO RX SPECIALTY CARE PHARMACY

Infusion Specialist:

GI INFUSION REFERRAL FORM

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: _____ ❑Male ❑Female SS#: _____ DOB: _____
Address: _____ City, State, Zip: _____
Primary Phone: _____ ❑Home ❑Cell ❑Work Alternate Phone: _____ ❑Home ❑Cell ❑Work
Email: _____ Height: _____ Weight: _____
Allergies: _____ Comorbidities: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Office Contact: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: _____
Date Shipment Needed By: _____ ❑Alternate Location: _____
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis/ICD-10: K50. _____
K51. _____
Date of Diagnosis: _____
Patient has negative TB test results? ❑ yes ❑ no Date of Test: _____
Prior History: ❑ 5-ASA ❑ Immunosuppressants (6-MP or other) ❑ Corticosteroids
❑ Methotrexate ❑ Surgery ❑ Other: _____

Prior Biologic Use: Date of Last Dose:
❑ Cimzia® _____
❑ Humira® _____
❑ Remicade™ _____
❑ Simponi® _____
❑ Inflectra _____
❑ Entyvio _____
❑ Stelara® _____
❑ Other (please specify) _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	REFILL
❑ Entyvio®	❑ 300mg vial	❑ Initial: Infuse 300 mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3) ❑ Maintenance: Infuse 300 mg IV over 30 minutes every _____ weeks (Quantity: 1)	
❑ Avsola® ❑ Inflectra® ❑ Remicade™ ❑ Renflexis™	❑ 100mg vial	❑ Initial: Infuse IV _____ mg per kg (Dose _____mg) at 0, 2, and 6 weeks (Quantity: _____) ❑ Maintenance: Infuse IV _____ mg per kg (Dose _____ mg) every _____ weeks (Quantity: _____) ❑ Other: _____ ❑ Pharmacist will round to the nearest 100 ❑ Give exact dose (do NOT round)	

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature | Date | Substitution Permissable - Signature | Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.