# GASTROENTEROLOGY REFERRAL FORM

Email: info@benevaspecialty.com
Fax: 805.371.0701
Phone: 805.371.0700

Beneva Specialty Pharmacy
375 Rolling Oaks Dr., Suite 150
Thousand Oaks, CA 91361
**NPI: 1316428808**

Beneva SPECIALTY PHARMACY

**Ship to:** ☐ Patient ☐ Prescriber ☐ Other _____

## PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Allergies: _____ ☐ NKDA
Phone: _____ Alternate Phone: _____
Email: _____ Preferred Contact: ☐ Phone ☐ Email
Emergency Contact: _____
Relationship to Patient: _____ Phone: _____

**INSURANCE INFORMATION:** Please fax a copy of prescription and insurance cards with this form (front and back)

## CLINICAL INFORMATION

**Diagnosis (ICD-10):** Date of Diagnosis: _____

☐ B18.1 Hepatitis B ☐ K76.82 Hepatic Encephalopathy ☐ A09 Traveler's Diarrhea ☐ K20.0 Eosinophilic Esophagitis
☐ K50.90 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ K58.0 IBS w/Diarrhea ☐ Other: _____

**Treatment Status:** ☐ New to Therapy ☐ Continuation of Therapy **Date of Last Treatment:** _____ **Needs By:** _____

**Weight:** _____ lb/kg **Height:** _____ in/cm **TB Result:** _____ **Date:** _____

**Therapy Tried and Failed** (please list medication and duration): _____
**Response:** ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side effects ☐ Other: _____

## PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QTY | REFILLS |
|---|---|---|---|---|
| ☐ **Cimzia** | ☐ Starter Kit 200 mg<br>☐ 200 mg/mL PFS | ☐ **Initial Dose:** Inject 400 mg SQ once, then repeat at week 2 and 4<br>☐ **Maintenance Dose:** Inject 400 mg SQ every 4 weeks | 6 PFS<br>2 PFS | None<br>_____ |
| ☐ **Dupixent** *(12+ years old, ≥ 40kg)* | ☐ 300 mg/2mL Prefilled PEN<br>☐ 300 mg/mL PFS | ☐ Inject 300 mg SQ every week | 4 | _____ |
| ☐ **Humira** | ☐ Citrate Free Crohn's/UC Starter Pack (80 mg/0.8mL x3 PENS)<br>☐ Citrate Free 40 mg/0.4mL PEN<br>☐ Citrate Free 40 mg/0.4mL PFS | ☐ **Initial Dose:** Inject 160 mg SQ on day 1, then 80 mg on day 15<br>☐ **Maintenance Dose:** Inject 40 mg SQ every other week starting on day 29<br>☐ **Other:** _____ | 3<br>2<br>_____ | None<br>_____<br>_____ |
| ☐ **Rinvoq** | ☐ 15 mg ER Tablet<br>☐ 30 mg ER Tablet<br>☐ 45 mg ER Tablet | ☐ **Initial Dose (UC):** Take 45 mg by mouth every day x8 weeks<br>☐ **Initial Dose (CD):** Take 45 mg by mouth every day x12 weeks<br>☐ **Maintenance Dose:** Take 15 mg by mouth every day<br>☐ **Other:** _____ | 28<br>28<br>30<br>_____ | 1<br>2<br>_____<br>_____ |
| ☐ **Simponi** | ☐ 100 mg/mL Autoinjector<br>☐ 100 mg/mL PFS | ☐ **Initial Dose:** Inject 200 mg SQ at week 0, then 100 mg at week 2<br>☐ **Maintenance Dose:** Inject 100 mg SQ every 4 weeks starting at week 6 | 3<br>1 | None<br>_____ |
| ☐ **Skyrizi** | ☐ 600 mg/10mL Vial<br>☐ 360 mg/2.4mL Prefilled Cartridge | ☐ **Initial Dose:** 600 mg IV at week 1, 4, and 8<br>☐ **Maintenance Dose:** 360 mg SQ every 8 weeks starting at week 12 | 3 vials<br>1 | None<br>_____ |

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|---|---|---|---|---|
| ☐ **Stelara** | ☐ 130 mg/25 mg SDV<br>☐ 90mg/mL PFS | **Initial Dose (select one below):**<br>☐ **≤ 55kg:** 260 mg (2 vials) IV as single dose<br>☐ **55kg to 85kg:** 390 mg (3 vials) IV as single dose<br>☐ **>85kg:** 520 mg(4 vials) IV as a single dose<br>☐ **Maintenance Dose:** Inject 90 mg SQ every 8 weeks; begin maintenance dose 8 weeks after the IV induction dose | <br>2 vials<br>3 vials<br>4 vials<br>1 PFS | <br>None<br>None<br>None<br>_____ |
| ☐ **Vemlidy** | ☐ 25 mg Tablet | ☐ Take 1 tablet by mouth every day with food | 30 tabs | _____ |
| ☐ **Xeljanz** | ☐ 5 mg Tablet<br>☐ 10 mg Tablet | ☐ **Initial Dose:** Take 1 tablet by mouth twice a day x8 weeks or _____ weeks<br>**Maintenance Dose:**<br>☐ Take 5 mg by mouth twice a day<br>☐ Take 10 mg by mouth twice a day | _____<br><br>60 tabs<br>60 tabs | _____<br><br>_____<br>_____ |
| ☐ **Xifaxan** | ☐ 200 mg<br>☐ 550 mg | ☐ **Traveler's Diarrhea:** Take 200 mg by mouth three times a day x3days | 9 | None |
| | | ☐ **Hepatic Encephalopathy:** Take 550 mg by mouth twice a day | 60 | _____ |
| | | ☐ **IBS w/Diarrhea:** Take 550 mg by mouth three times a day x14days | 42 | None |
| ☐ Other (drug and strength):<br>_____ | | _____ | _____ | _____ |
| ☐ Other (drug and strength):<br>_____ | | _____ | _____ | _____ |

## PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone:_____

## PRESCRIBER SIGNATURE (DO NOT STAMP)

| | |
|---|---|
| "Dispense as Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May No Substitute | May Substitute / Product Selection Permitted / Substitution Permissible |
| Prescriber's Signature: _____<br>Date: _____ | Prescriber's Signature: _____<br>Date: _____ |

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Beneva Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA requests as my signature.

**End of Referral Form**