axiva
Gastroenterology
Patient Referral Form

Infusion Specialist
c:
e:

PATIENT INFORMATION

Date: Patient Name: Last 4 SSN DOB:

Address: City: ST: Zip:

Primary Phone: Work Phone:

Gender: ☐ M ☐ F Weight lbs/kg: Height: Allergies:

Primary Insurance: **Secondary Insurance:**

Member#: **Group#:** **Member#:** **Group#:**

Diagnosis: _____

Documentation needed: ☑ Insurance cards ☑ Most recent clinical including H&P ☑ Labs ☑ Diagnostic testing results

Medication	Order
Cimzia – Subcutaneous or IV (suite only)	☐ Initial: 400 mg week 0, week 2, week 4, then maintenance ☐ Maintenance: 400 mg every 2 weeks ☐ Other: ☐ Sub-Q ☐ IV (Suite Only)
Dupixent - Subcutaneous	☐ 300 mg sub-Q every week ☐ Other:
Entyvio - IV	☐ Initial: 300 mg week 0, week 2, week 6, then maintenance ☐ Maintenance: Every 8 weeks ☐ Other:
Humira - Subcutaneous	☐ Induction: 160 mg sub-Q day 1, 80 mg day 15 ☐ Maintenance: 40 mg sub-Q every other week ☐ Other:
Infliximab - IV ☐ Remicade ☐ Inflectra ☐ Renflexis	☐ 5 mg/kg ☐ 10mg/kg ☐ _____ mg/kg ☐ _____ mg Freq: ☐ Initial: week 0, week 2, week 6, then maintenance ☐ Maintenance: Every 8 weeks ☐ Every _____ weeks
Simponi - Subcutaneous	☐ Initial: 200 mg sub-Q week 0, 100 mg week 2, then maintenance ☐ Maintenance: 100 mg sub-Q every 4 weeks ☐ Other:
Simponi Aria - IV	☐ Initial: 2mg/kg week 0 and 4, then maintenance ☐ Other: ☐ Maintenance: Every 8 weeks ☐ Other:
Skyrizi – Subcutaneous/IV (initial only)	☐ Initial *IV*: 600 mg week 0, week 4, and week 8, then subcutaneous maintenance ☐ Maintenance *Subcutaneous*: ☐ 180 mg ☐ 360 mg week 12 and every 8 weeks thereafter ☐ Other:
Stelara - Subcutaneous	☐ 90 mg ☐ Every 8 weeks ☐ Every _____ weeks
Stelara - IV (Suite Only)	☐ 260 mg ☐ 390 mg ☐ 520 mg One time initial dose, then maintenance via subcutaneous injections

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Tysabri – IV (Suite Only) IV	☐ 300 mg Freq: Every 4 weeks
Xeljanz - Oral	☐ Induction: ☐ 10 mg PO twice daily ☐ 22 mg XR PO once daily For _____ weeks ☐ Maintenance: ☐ 5 mg PO twice daily ☐ 11 mg XR PO once daily ☐Other:

Nursing

☑ Establish and/or maintain access device as needed for dose administration
☑ Administer by ordered route
☑ Obtain vital signs prior to, throughout as directed and at completion of infusion
☑ If reaction occurs follow procedure reaction management

PROVIDER INFORMATION

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.

Physician Name: NPI: DEA: License:

Address: City: ST: Zip:

Phone: Fax: Office Contact:

_____ _____ ♦ _____ _____
Physician Signature Required – Substitution Permitted Date Physician Signature Required – Dispense as Written Date

FAX completed form to Axiva 844.440.0101 **Intake Specialist: 844.44-AXIVA (844.442.9482)**