

## **CROHN'S DISEASE REFERRAL FORM**

TEL 813.880.2500 FAX 813.880.2501 TOLL FREE 1.866.880.2507

| PATIENT INFORMATION                 | 1   |  |   |             |  |
|-------------------------------------|---|--|---|-------------|--|
| Name:                               | Address:                                  |  | Phone:  |             |  |
| SSN:                                | DOB:                                      | Sex:   |   |             |  |
| Weight: H                           | eight: Allergie                           | s: Shi   | Ship to: □ Patient □ Clinic                                 |             |  |
| INSURANCE                           |   |  |   |             |  |
| Prescription Card: Name of Insurer: |   | ID#  | BIN: PCI  | N:          |  |
| Group:                              | ( please attach copies of insu            | rance cards )  |   |             |  |
| DIAGNOSIS                           |   |  |   |             |  |
| ☐ K50.0 Crohn's Disease             | ☐ K51.9 Ulcerative Colitis Has TB to      | est been done? □Yes □No Date;  |   |             |  |
| Test Result:                        |   | Does the patient have an ac  | tive infection? □Yes □No                                    |             |  |
| Current medications includ          | ling OTC:                                 | <u> </u>   |   |             |  |
| Prior Failed Medications?           |   | Start Date:  | End Date:   |             |  |
| Reason for DC:                      |   |  |   |             |  |
|                                     |   |  |   |             |  |
| PRESCRIPTION INFORM                 | 1ATION                                    |  |   |             |  |
| Medication                          | Dose                                      | Directions   | Quantity  | Refill      |  |
| ☐ Cimzia (Certolizumab)             | □ 200 mg/ml PFS                           | ☐ Initial: Inject 400 mg SC at 0,<br>2 And 4 weeks                                     | □ 6 X 200 mg/ml   | 0           |  |
|                                     | ☐ 200 mg vials                            | Maintenance: ☐ Inject 400 mg SC every 4 weeks  | □ 2 X 200 mg/ml   |             |  |
| ☐ Humira (Adalimumab)               | ☐ 40 mg/0.8ml pens                        | ☐ Initial - 160 mg SC on day 1,<br>then 80 mg SC on Day 15                             | ☐ 6 X 40 mg/0.8ml   | 0           |  |
|                                     |   | Maintenance: ☐ 40 mg SC every other week beginning                                     | g □ 2 X 40 mg/0.8ml   |             |  |
|                                     |   | on Day 29<br>☐ 40 mg SC every week   | □ 4 X 40 mg/0.8ml   |             |  |
| ☐ Simponi (Golimumab)               | ☐ 100 mg/ml Autoinjector                  | ☐ Initial 200 mg SC at week 0, then 100 mg at week 2                                   | ☐ 3 X 100 mg/ml   | 0           |  |
|                                     | ☐ 100 mg/ml PFS                           | Maintenance: ☐ 100 mg SC every 4 weeks   | ☐ 1 X 100 mg/ml   |             |  |
| □ Stelara (Ustekinumab)             | ☐ 130 mg/26ml vial                        | Initial:  □ ≤55 Kg: 260 mg IV x 1  □ >55-85 Kg: 390 mg IV x 1  □ >85 Kg: 520 mg IV x 1 | ☐ 2 X 130 mg/26ml<br>☐ 3 X 130 mg/26ml<br>☐ 4 X 130 mg/26ml | 0<br>0<br>0 |  |
|                                     | □ 90 mg PFS                               | Maintenance: ☐ 90 mg SC every 8 weeks (Start 8 weeks after IV Induction)               | □ 1 X 90 mg/ml  |             |  |
| ☐ Other                             |   |  |   |             |  |
| -                                   |   |  |   |             |  |
| PRESCRIBER INFORMAT                 | TION                                      |  |   |             |  |
| Physicain Name:                     |   | Address:   |   |             |  |
| •                                   | NPI:                                      |  |   |             |  |
|                                     |   |  | Office Contact Name /Number:                                |             |  |
|                                     | Signature:Date:                           |  |   |             |  |
| Lauthorize pharmax specia           | Ity pharmacy and its representatives to a | ct as an agent to initiate and execute the insurance pri                               | or authorization process                                    |             |  |

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