

Phone: 800.511.5144 • Fax: 877.541.1503

**CROHN'S DISEASE AND ULCERATIVE COLITIS REFERRAL FORM A-Si**

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:		Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> Additional Information Attached		
PRESCRIBER INFORMATION					
Prescriber:		NPI:	DEA:	State Lic:	
Supervising Physician:		Practice Name:			
Address:		City:	State:	Zip:	
Phone:	Fax:	Key Office Contact:		Phone:	
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT					
<b>Primary Diagnosis:</b> (ICD-10 Code & Description) <input type="checkbox"/> K50.00 <input type="checkbox"/> K50.10 <input type="checkbox"/> K50.80 <input type="checkbox"/> K50.90 Crohn's Disease <input type="checkbox"/> K51.9 Ulcerative Colitis <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No    Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No    Please list medication(s) and treatment duration: _____					
<input type="checkbox"/> Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, how long should patient wait before starting the new medication? _____					
<input type="checkbox"/> Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____					
<input type="checkbox"/> Has patient received a <b>Quatiferon gold, Tspot or PPD (tuberculosis) Skin Test?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive					
INSURANCE INFORMATION					
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)					
COPAY CARD ENROLLMENT					
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____			
PRESCRIPTION INFORMATION					
<input type="checkbox"/> <b>STC Standard Protocol</b> will include the following: (1) dispensing ordered med/dose, (2) diluent to mix and/or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg/mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).					
<input type="checkbox"/> <b>Cimzia® 200 mg/mL Prefilled Syringe</b> <input type="checkbox"/> <b>Cimzia® 200 mg Vial</b> *Cimza Prefilled Syringes will be dispensed unless MD selects Vial. <small>*Note: Cimzia Vial should be prepared and administered by a health care professional. AcariaHealth will coordinate home care with Cimplicity™ Program.</small>					
<input type="checkbox"/> Starter Dose: 400 mg SQ (2 inj. of 200 mg) initially at Week 0, repeat at Weeks 2 and 4 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 400 mg SQ every 4 weeks <input type="checkbox"/> 200 mg SQ every 2 weeks				<input type="checkbox"/> Enroll in Cimplicity™ Program QTY: <u>1 starter kit (6 PFS)</u> Refills: <u>0</u> QTY: <u>1 box (2 x 200 mg)</u> Refills: _____	
<input type="checkbox"/> <b>Entyvio® 300 mg Vial</b> <input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required					
<input type="checkbox"/> Starter Dose: 300 mg IV at Week 0, Week 2, Week 6 <input type="checkbox"/> Maintenance Dose: 300 mg IV every 8 weeks				QTY: <u>3 vials</u> Refills: <u>0</u> QTY: <u>1 vial</u> Refills: _____	
<input type="checkbox"/> <b>Humira® Starter Package CF 80 mg / 0.8 mL Pen NDC: 0074-0124-03</b> Starter Dose: <input type="checkbox"/> Two 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 15 <input type="checkbox"/> One 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 2, one 80 mg SQ inj. Day 15					
<input type="checkbox"/> <b>Humira® CF 40 mg/0.4 mL Pen NDC: 0074-0554-02</b> <input type="checkbox"/> <b>Humira® CF 40 mg/0.4 mL Prefilled Syringe NDC: 0074-0243-02</b> Maintenance Dose: <input type="checkbox"/> One 40 mg SQ inj. Day 29 & every other week thereafter <input type="checkbox"/> Alternate Dose: _____					
<input type="checkbox"/> <b>Remicade® 100 mg Vial</b> <input type="checkbox"/> <b>Inflectra® 100 mg Powder Vial</b> <input type="checkbox"/> <b>Renflexis® 100 mg Powder Vial</b> <input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required <input type="checkbox"/> Starter Dose: _____ mg    IV on Week 0, Week 2, Week 6, then _____ <input type="checkbox"/> Maintenance Dose: _____ mg    IV every _____ weeks				<input type="checkbox"/> Enroll in AccessOneSM Program QTY: _____                      Refills: <u>0</u> QTY: _____                      Refills: _____	
<input type="checkbox"/> <b>Rinvoq®</b> <input type="checkbox"/> Rinvoq 45mg tab Starter Dose: 45 mg once daily x 8 weeks <input type="checkbox"/> Rinvoq 15mg tab Maintenance Dose: 15 mg once daily <input type="checkbox"/> Rinvoq 30mg tab Alternate Maintenance Dose: 30 mg once daily for pts w/severe, or refractory disease					
<input type="checkbox"/> <b>Simponi® SmartJect 100 mg/mL</b> <input type="checkbox"/> <b>Simponi® Prefilled Syringe 100 mg/mL</b> <small>Simponi SmartJect will be dispensed unless MD selects Prefilled Syringes</small> <input type="checkbox"/> Starter Dose: 200 mg SQ at Week 0, 100 mg at Week 2, then start maintenance at Week 6 <input type="checkbox"/> Maintenance Dose: 100 mg SQ every 4 weeks starting at Week 6 <input type="checkbox"/> Alternate Dose: _____				QTY: <u>3</u> Refills: <u>0</u> QTY: <u>1</u> Refills: _____ QTY: _____                        Refills: _____	

**Physician's Signature:** \_\_\_\_\_  DAW (Dispense as Written) **Date:** \_\_\_\_\_

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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