

Date Shipment Needed: \_\_\_\_\_ Ship To:  Patient  Prescriber  
 Nursing needed;  Training needed ► All the supplies including syringes and needles will be dispensed if needed.

## CROHN'S DISEASE AND ULCERATIVE COLITIS REFERRAL FORM

PATIENT INFORMATION			
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
SSN:		Phone:	Allergies:
Address:		City:	State: Zip:
Emergency Contact:		Phone:	<input type="checkbox"/> Please attach demographic information
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 Crohn's Disease <input type="checkbox"/> K50.10 <input type="checkbox"/> K50.80 <input type="checkbox"/> K50.90 <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 <input type="checkbox"/> 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): _____			
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"/> STC standard protocol will include dispensing ordered med/dose, diluent to mix and/or dilute dose, flushes to flush line and anakit med (epinephrine & diphenhydramine 50 mg/mL ) and basic premeds; Apap 325-650 mg and diphenhydramine 25-50 mg oral.			
<input type="checkbox"/> <b>Cimzia® 200 mg/mL Prefilled Syringe (OR)</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"/> <b>Enroll in Cimplicity™ Program</b> QTY: <u>1 starter kit (6 PFS)</u> Refills: <u>0</u> QTY: <u>1 box (2 x 200mg)</u> Refills: _____	
<input type="checkbox"/> Starter Dose: 400 mg SQ (2 inj. of 200 mg) initially (Week 0), repeat at Weeks 2 and 4 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 400 mg SQ every 4 weeks (OR) <input type="checkbox"/> 200 mg SQ every 2 weeks			
<input type="checkbox"/> <b>Entyvio® 300 mg Vial</b> <input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies <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: _____ QTY: <u>2</u> Refills: _____	
<input type="checkbox"/> <b>EpiPen® 0.3 mg IM x 1</b> , may repeat			
<input type="checkbox"/> <b>Humira® Starter Package CF 80 mg/0.8 mL Pen NDC: 0074-0124-03</b> *Humira Pens will be dispensed unless MD selects Prefilled Syringes 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>Enroll in Humira Complete Program</b> QTY: <u>3 pens</u> Refills: <u>0</u> QTY: <u>3 pens</u> Refills: <u>0</u>	
<input type="checkbox"/> <b>Humira® CF40 mg/0.4 mL Pen NDC: 0074-0554-02 (OR)</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: _____		QTY: <u>2</u> Refills: _____ QTY: _____ Refills: _____	
<input type="checkbox"/> <b>Remicade® 100 mg 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"/> <b>Enroll in AccessOneSM Program</b> QTY: _____ Refills: <u>0</u> QTY: _____ Refills: <u>0</u>	
<input type="checkbox"/> <b>Simponi® SmartJect 100 mg/mL (OR)</b> <input type="checkbox"/> <b>Simponi® Prefilled Syringe 100 mg/mL</b> Simponi SmartJect will be dispensed unless MD selects Prefilled Syringes <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: _____	
<input type="checkbox"/> <b>Stelara®</b> <input type="checkbox"/> Induction Dose: IV Infusion 130 mg/26 mL (5 mg/mL) single-dose vial, weight-based <input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required <input type="checkbox"/> Less than or equal to 55 kg: IV Infusion 260 mg (2 vials) once <input type="checkbox"/> Greater than 55 kg to 85 kg: IV Infusion 390 mg (3 vials) once <input type="checkbox"/> Greater than 85 kg: IV Infusion 520 mg (4 vials) once <input type="checkbox"/> Maintenance Dose: 90 mg/mL in a single-dose Prefilled Syringe <input type="checkbox"/> Home Injection Dose: SQ inj. 90 mg 8 weeks after the initial IV dose, then every 8 weeks thereafter		<input type="checkbox"/> <b>Enroll in Janssen CarePath Program</b> QTY: <u>2</u> Refills: <u>0</u> QTY: <u>3</u> Refills: <u>0</u> QTY: <u>4</u> Refills: <u>0</u> QTY: <u>1</u> Refills: _____	
<input type="checkbox"/> <b>Xeljanz®</b> <input type="checkbox"/> 5 mg tablet (OR) <input type="checkbox"/> 10 mg tablet <input type="checkbox"/> 5 mg twice daily (OR) <input type="checkbox"/> 10 mg twice daily <input type="checkbox"/> Other _____		QTY: _____ Refills: _____ QTY: _____ Refills: _____ QTY: _____ Refills: _____	

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

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or 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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