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

Phone: 800.511.5144 • Fax: 877.541.1503

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

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐M ☐F ☐Other:	Weight:	☐lbs. ☐kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐**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

Primary Diagnosis: (ICD-10 Code & Description) ☐K50.00 ☐K50.10 ☐K50.80 ☐K50.90 Crohn's Disease ☐K51.9 Ulcerative Colitis ☐Other: _____

- Has patient been treated *previously* for this condition? ☐Yes ☐No Is patient *currently* on therapy? ☐Yes ☐No Please list medication(s) and treatment duration:
  _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐Yes ☐No If *yes*, how long should patient wait before starting the new medication?
  _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
  _____
- Has patient received a **Quatiferon gold**, **Tspot** or **PPD (tuberculosis) Skin Test**? ☐Yes ☐No Date: _____ Results: ☐Negative ☐Positive

INSURANCE INFORMATION

☐**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐**Please check if enrolling in copay card** **Copay ID:**

PRESCRIPTION INFORMATION

☐**STC Standard Protocol** 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).

☐**Cimzia® 200 mg/mL Prefilled Syringe** ☐**Cimzia® 200 mg Vial** **Cimza Prefilled Syringes will be dispensed unless MD selects Vial.*
**Note: Cimzia Vial should be prepared and administered by a health care professional. AcariaHealth will coordinate home care with Cimplicity™ Program.*
☐**Enroll in Cimplicity™ Program**
☐Starter Dose: 400 mg SQ (2 inj. of 200 mg) initially at Week 0, repeat at Weeks 2 and 4 QTY: 1 starter kit (6 PFS) Refills: 0
☐Maintenance Dose: ☐400 mg SQ every 4 weeks ☐200 mg SQ every 2 weeks QTY: 1 box (2 x 200 mg) Refills: _____

☐**Entyvio® 300 mg Vial** ☐ MD's Office Infusion ☐Home Infusion Supplies Required
☐Starter Dose: 300 mg IV at Week 0, Week 2, Week 6 QTY: 3 vials Refills: 0
☐Maintenance Dose: 300 mg IV every 8 weeks QTY: 1 vial Refills: _____

☐**Humira® Starter Package CF 80 mg / 0.8 mL Pen** *NDC: 0074-0124-03* ☐**Enroll in Humira Complete Program**
Starter Dose: ☐Two 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 15 QTY: 3 pens Refills: 0
☐One 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 2, one 80 mg SQ inj. Day 15 QTY: 3 pens Refills: 0
☐**Humira® CF 40 mg/0.4 mL Pen** *NDC: 0074-0554-02* ☐ **Humira® CF 40 mg/0.4 mL Prefilled Syringe** *NDC: 0074-0243-02*
Maintenance Dose: ☐One 40 mg SQ inj. Day 29 & every other week thereafter QTY: 2 Refills: _____
☐Alternate Dose: _____ QTY: _____ Refills: _____

☐**Remicade® 100 mg Vial** ☐**Inflectra® 100 mg Powder Vial** ☐**Renflexis® 100 mg Powder Vial**
☐**Enroll in AccessOneSM Program**
☐MD's Office Infusion ☐Home Infusion Supplies Required
☐Starter Dose:_____mg IV on Week 0, Week 2, Week 6, then _____ QTY: _____ Refills: 0
☐Maintenance Dose:_____mg IV every_____weeks QTY: _____ Refills: _____

☐**Rinvoq®**
☐Rinvoq 45mg tab Starter Dose: 45 mg once daily x 8 weeks QTY: 28 Refills: 1
☐Rinvoq 15mg tab Maintenance Dose: 15 mg once daily QTY: 30 Refills: _____
☐Rinvoq 30mg tab Alternate Maintenance Dose: 30 mg once daily for pts w/severe, or refractory disease QTY: 30 Refills: _____

☐**Simponi® SmartJect 100 mg/mL** ☐**Simponi® Prefilled Syringe 100 mg/mL** *Simponi SmartJect will be dispensed unless MD selects Prefilled Syringes*
☐Starter Dose: 200 mg SQ at Week 0, 100 mg at Week 2, then start maintenance at Week 6 QTY: 3 Refills: 0
☐Maintenance Dose: 100 mg SQ every 4 weeks starting at Week 6 QTY: 1 Refills: _____
☐Alternate Dose:_____ 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.

Rev: 1.19.23

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