

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 Sk-Z

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					
Primary Diagnosis: (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 Quatiferon gold, Tspot or PPD (tuberculosis) Skin Test? <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 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"/> Skyrizi®					
<input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required		<input type="checkbox"/> Skyrizi 600mg vial Starter Dose: 600 mg IV on Week 0, Week 4, Week 8		QTY: <u> 3 </u>	Refills: <u> 0 </u>
<input type="checkbox"/> Skyrizi 360mg On-Body Injector Maintenance Dose: 360 mg SQ on week 12 and every 8 weeks thereafter		<input type="checkbox"/> Skyrizi 180mg On-Body Injector Maintenance Dose: 180 mg SQ on week 12 and every 8 weeks thereafter		QTY: <u> 1 </u>	Refills: <u> </u>
<input type="checkbox"/> Skyrizi 180mg On-Body Injector Maintenance Dose: 180 mg SQ on week 12 and every 8 weeks thereafter		<input type="checkbox"/> Skyrizi 180mg On-Body Injector Maintenance Dose: 180 mg SQ on week 12 and every 8 weeks thereafter		QTY: <u> 1 </u>	Refills: <u> </u>
<input type="checkbox"/> Stelara® <input type="checkbox"/> Enroll in Janssen CarePath Program					
<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		QTY: <u> 2 </u>	Refills: <u> 0 </u>
<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		QTY: <u> 3 </u>	Refills: <u> 0 </u>
<input type="checkbox"/> Greater than 85 kg: IV Infusion 520 mg (4 vials) once		<input type="checkbox"/> Maintenance Dose: 90 mg/mL single-dose Prefilled Syringe <input type="checkbox"/> Home Injection Dose: SQ inj. 90 mg 8 weeks after first IV dose, every 8 weeks thereafter		QTY: <u> 4 </u>	Refills: <u> 0 </u>
<input type="checkbox"/> Maintenance Dose: 90 mg/mL single-dose Prefilled Syringe <input type="checkbox"/> Home Injection Dose: SQ inj. 90 mg 8 weeks after first IV dose, every 8 weeks thereafter		<input type="checkbox"/> Maintenance Dose: 90 mg/mL single-dose Prefilled Syringe <input type="checkbox"/> Home Injection Dose: SQ inj. 90 mg 8 weeks after first IV dose, every 8 weeks thereafter		QTY: <u> 1 </u>	Refills: <u> </u>
<input type="checkbox"/> Xeljanz® Starter Dose 10 mg Oral Tablet					
<input type="checkbox"/> Starter dose: 1 tablet twice daily		<input type="checkbox"/> Other: _____		QTY: <u> 60 </u>	Refills: <u> 1 </u>
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Xeljanz® 5 mg Oral Tablet <input type="checkbox"/> Xeljanz® 10 mg Oral Tablet					
<input type="checkbox"/> Maintenance Dose: 1 tablet twice daily		<input type="checkbox"/> Other: _____		QTY: <u> 60 </u>	Refills: <u> </u>
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Xeljanz XR® Starter Dose 22 mg Oral Tablet					
<input type="checkbox"/> Starter Dose: Once daily		<input type="checkbox"/> Other: _____		QTY: <u> 30 </u>	Refills: <u> 1 </u>
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Xeljanz XR® 11 mg Oral Tablet <input type="checkbox"/> Xeljanz XR® 22 mg Oral Tablet					
<input type="checkbox"/> Maintenance Dose: 1 tablet PO once daily		<input type="checkbox"/> Other: _____		QTY: <u> 30 </u>	Refills: <u> </u>
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Zeposia® Oral capsules					
Directions: Days 1-4: 0.24mg by mouth once daily, Days 5-7: 0.46mg by mouth once daily Day 8 and thereafter: 0.92mg by mouth once daily					
<input type="checkbox"/> New Patient: Zeposia starter kit (7 day starter pack followed by 30 day supply)		<input type="checkbox"/> Patients restarting: 7-day titration		QTY: <u> 1 Kit (37 capsules) </u>	Refills: <u> 0 </u>
<input type="checkbox"/> Maintenance Dose: 0.92 mg by mouth once daily		<input type="checkbox"/> Other: _____		QTY: <u> 1 Kit (7 capsules) </u>	Refills: <u> 0 </u>
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____		QTY: <u> </u>	Refills: <u> </u>

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.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

AcariaHealth™

Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503