AcariaHealth™
An envolve Pharmacy Solution

Phone: 800.511.5144 • Fax: 877.541.1503

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: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:	Phone:		❑ **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 ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) ❑K50.00 Crohn's Disease ❑K50.10 ❑K50.80 ❑K50.90 ❑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 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.

❑**Cimzia® 200 mg/mL Prefilled Syringe (OR)** ❑**Cimzia® 200 mg Vial** **Cimza Prefilled Syringes will be dispensed unless MD selects Vial* — ❑**Enroll in Cimplicity™ Program**

**Note: Cimzia vial should be prepared and administered by a health care professional. AcariaHealth will coordinate home care with Cimplicity™ Program.*

- ❑Starter Dose: 400 mg SQ (2 inj. of 200 mg) initially (Week 0), repeat at Weeks 2 and 4 — QTY: 1 starter kit (6 PFS) Refills: 0
- ❑Maintenance Dose: ❑400 mg SQ every 4 weeks **(OR)** ❑200 mg SQ every 2 weeks — QTY: 1 box (2 x 200mg) Refills: _____

❑**Entyvio® 300 mg Vial** ❑ MD's Office Infusion ❑Home Infusion Supplies

- ❑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: _____

❑**EpiPen® 0.3 mg** IM x 1, may repeat — QTY: 2 Refills: _____

❑**Humira® Starter Package CF 80 mg/0.8 mL Pen** *NDC: 0074-0124-03 *Humira Pens will be dispensed unless MD selects Prefilled Syringes* — ❑**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® CF40 mg/0.4 mL Pen** *NDC: 0074-0554-02* **(OR)** ❑ **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** ❑MD's Office Infusion ❑Home Infusion Supplies Required — ❑**Enroll in AccessOneSM Program**

- ❑Starter Dose:____________mg IV on Week 0, Week 2, Week 6, then ______________________________ QTY: _____ Refills: 0
- ❑Maintenance Dose:________mg IV every________weeks — QTY: _____ Refills: 0

❑**Simponi® SmartJect 100 mg/mL (OR)** ❑**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: _____

❑**Stelara®** — ❑**Enroll in Janssen CarePath Program**

- ❑Induction Dose: IV Infusion 130 mg/26 mL (5 mg/mL) single-dose vial, weight-based ❑MD's Office Infusion ❑Home Infusion Supplies Required
  - ❑Less than or equal to 55 kg: IV Infusion 260 mg (2 vials) once — QTY: 2 Refills: 0
  - ❑Greater than 55 kg to 85 kg: IV Infusion 390 mg (3 vials) once — QTY: 3 Refills: 0
  - ❑Greater than 85 kg: IV Infusion 520 mg (4 vials) once — QTY: 4 Refills: 0
- ❑Maintenance Dose: 90 mg/mL in a single-dose Prefilled Syringe ❑Home Injection Dose: SQ inj. 90 mg 8 weeks after the initial IV dose, then every 8 weeks thereafter — QTY: 1 Refills: _____

❑**Xeljanz®**

- ❑5 mg tablet **(OR)** ❑10 mg tablet — QTY: _____ Refills: _____
- ❑5 mg twice daily **(OR)** ❑10 mg twice daily — QTY: _____ Refills: _____
- ❑Other ______________________________ 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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