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 U-Z

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).

☐**Velsipity 2mg tablet**
- ☐ take 1 tablet (2mg) by mouth once daily — QTY: 30 — Refils: _____

☐ **Xeljanz® Starter Dose 10 mg Oral Tablet**
- ☐Starter dose: 1 tablet PO twice daily for 8 weeks — QTY: 60 — Refills: 1
- ☐Other _____ — QTY: _____ — Refills: _____

☐**Xeljanz® 5 mg Oral Tablet** ☐**Xeljanz® 10 mg Oral Tablet**
- ☐ Maintenance Dose: 1 tablet PO twice daily — QTY: 60 — Refills: _____
- ☐Other _____ — QTY: _____ — Refills: _____

☐ **Xeljanz XR® Starter Dose 22 mg Oral Tablet**
- ☐Starter Dose: 1 tablet PO once daily for 8 weeks — QTY: 30 — Refills: 1
- ☐Other:_____ — QTY: _____ — Refills: _____

☐**Xeljanz XR® 11 mg Oral Tablet** ☐ **Xeljanz XR® 22 mg Oral Tablet**
- ☐Maintenance Dose: 1 tablet PO once daily — QTY: 30 — Refills: _____
- ☐Other:_____ — QTY: _____ — Refills: _____

☐**Zeposia® Oral capsules**
Directions: Days 1-4: 0.23mg by mouth once daily, Days 5-7: 0.46mg by mouth once daily Day 8 and thereafter: 0.92mg by mouth once daily
- ☐New Patient: Zeposia starter kit (7 day starter pack followed by 30 day supply) — QTY: 1 Kit (37 capsules) — Refills: 0
- ☐ Patients restarting: 7-day titration — QTY: 1 Kit (7 capsules) — Refills: 0
- ☐ Maintenance Dose: 0.92 mg by mouth once daily — QTY: _____ — Refills: _____

☐**Other**:_____ — 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 receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.