Date:_____

Crohn's/Ulcerative Colitis Referral Form

PATIENT INFORMATION:

Patient Name: _____
Address: _____
City, State, Zip: _____
Cell Phone: _____
Home Phone: _____Language:_____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Guardian/Caregiver & Number: _____

PRESCRIBER INFORMATION:

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA:_____ NPI: _____
Office Contact: _____

INSURANCE INFORMATION

Attach a copy of the Front and Back of the Insurance and Prescription Card. Prior Authorization Reference Number: _____

CLINICAL INFORMATION

DIAGNOSIS: ICD-10 code

Crohn's Disease
☐ K50.0 ☐ K50.1
☐ K50.8
☐ K50.9

Ulcerative Colitis
☐ K51.0 ☐ K51.2
☐ K51.3 ☐ K51.5
☐ K51.8 ☐ K51.9

☐ Other Diagnosis: _____
Date of Diagnosis: _____
Allergies: _____

Ship to: ☐ Patient ☐ Office ☐ First Fill to Office **Date Needed**: _____ **Weight(kg):** _____
CrCl: _____ **Hep B** rule out: ☐ Yes ☐ No **TB test** performed: ☐ Yes ☐ No Results: _____
Therapy ☐ New ☐ Reauthorization ☐ Restart **Immunizations Up-To-Date:** ☐ Yes ☐ No
Tx Response & Dates: _____
Injection Training: ☐ Patient trained ☐ Physician's office to train ☐ Pharmacy to coordinate training
Current/Prior Medications: ☐ **Azathioprine** ☐ **Corticosteroids** ☐ **5-ASA** ☐ **6-MP** ☐ **NSAIDS**
☐ **Methotrexate** ☐ **Sulfasalazine** ☐ **Other:** _____

	Dose/Strength	Directions	Quantity	Refills
☐ **Cimzia** (certolizumab)	☐ 200mg Starter kit ☐ 200 mg/ml vial ☐ 200 mg/ml PFS	☐ Initial Dose: Inject 400 mg SQ at week 0, week 2 and week 4 ☐ Inject 400 mg SQ every 4 weeks ☐ Inject 200 mg SQ every 2 weeks		
☐ **Entocort EC** (budesonide)	☐ 3 mg capsules	☐ Take 9 mg (3 capsules) by mouth every day.		
☐ **Entyvio** (vedolizumab)	☐ 300 mg vial ☐ MD Office Infusion ☐ Home Infusion Supplies	☐ Initial Dose: 300 mg IV over 30 minutes at week 0, week 2 and week 6 ☐ Maintenance Dose: 300 mg IV over 30 minutes every 8 weeks		
☐ **EpiPen** (epinephrine)	☐ 0.3 mg ☐ 0.15 mg (weight 15-30 kg)	☐ Inject 0.3 mg IM x 1, may repeat		
☐ **Humira CF** (adalimumab)	☐ 20mg/0.2ml PFS ☐ 40mg/0.4ml PFS ☐ 40mg/0.4ml pen ☐ 80mg/0.8ml pen	☐ Initial Dose: Inject 160 mg SQ on day 1 & 80 mg SQ on day 15 ☐ Initial Dose: Inject 80 mg SQ on day a & 40 mg on day 15 ☐ Maintenance Dose: Inject 40 mg SQ on day 29 & every other week ☐ Other: _____		
☐ **Humira** (adalimumab)	☐ 20mg/0.4ml PFS ☐ 40mg/0.8ml PFS ☐ 40mg/0.8ml pen ☐ 80mg/0.8ml pen			
☐ **Remicade** (infliximab) ☐ **Inflectra** ☐ **Renflexis**	☐ 5mg/kg ☐ 10mg/kg	☐ Initial Dose: Infuse _____ mg/kg IV at week 0, week 2, week 6 ☐ Maintenance Dose: Infuse _____mg/kg once every 8 weeks ☐ Other _____		
☐ **Simponi** (golimumab)	☐ 100 mg/ml Smartject Autoinjector ☐ 100 mg/ml PFS	☐ Initial Dose: Inject 200 mg SQ at week 0 then 100 mg SQ at week 2 ☐ Maintenance Dose: Inject 100 mg SQ every 4 weeks		
☐ **Stelara** (ustekinumab)	☐ 130 mg/26 ml solution single dose vial ☐ 90mg/ml PFS Date of Initial Infusion: _____	☐ Initial: Inject 260 mg (pt weight ≤ 55 kg) SQ on day 1 ☐ Initial: Inject 390 mg (pt weight < 56-85 kg) SQ on day 1 ☐ Initial: Inject 520 mg (pt weight > 85 kg) SQ on day 1 ☐ Maintenance: 8 weeks after Initial Dose: Inject 90 mg SQ every 8 weeks		
☐ **Uceris** (budesonide)	☐ 9mg ER tablet	☐ Take 9 mg tablet by mouth daily		
☐ **Xeljanz** (tofacitinib)	☐ 5 mg tablet ☐ 10 mg tablet	☐ Initial Dose: Take 10 mg PO twice daily (for 8-16 weeks) ☐ Maintenance Dose: Take 5 mg PO twice daily		
☐ **Xeljanz XR** (tofacitinib)	☐ 11 mg XR tablet ☐ 22 mg XR tablet	☐ Initial Dose: Take 22 mg PO once daily (for 8-16 weeks) ☐ Maintenance Dose: Take 11 mg PO once daily		
☐ **Xifaxan** (rifaximin)	☐ 200 mg tablet ☐ 550 mg tablet	☐ Take 200 mg tablet PO three times a day for 16 weeks ☐ Take 550 mg tablet by mouth three times a day for 14 days ☐ Other: _____		

Patient Support Programs: To enroll in manufacturer assisted patient support program: **Patient Signature: _____Date:_____**

PRESCRIBER SIGNATURE:_____ **DATE:**_____
Verbal Readback ☐ Yes ☐ No ***Stamp signature not allowed, physician signature required *** ☐ Product substitution permitted ☐ Dispense as written