

CROHN'S DISEASE/ULCERATIVE COLITIS REFERRAL FORM

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Patient Information

Patient Name: _____ DOB: _____ Sex: M F
 Phone: _____ Cell Phone: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip: _____
 ICD-10 Diagnosis Code: _____ Diagnosis: _____
 Allergies (please note reaction): _____ Latex
 Current Medications: (list here or attach a medication list): _____
 Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Cimzia (certolizumab)	<input type="checkbox"/> Starter Kit 200mg/mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 400mg (2 syringes) subcutaneously at weeks 0, 2 and 4.	1 kit (6 syringes)	
	<input type="checkbox"/> 200mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 400mg (2 syringes) subcutaneously every 4 weeks.	28-day supply	
<input type="checkbox"/> Entyvio (vedolizumab)	300mg Solution	<input type="checkbox"/> Loading Dose: Administer 300mg intravenously at 0, 2 and 6 weeks.	42-day supply	
		<input type="checkbox"/> Maintenance Dose: Administer 300mg intravenously every 8 weeks.	56-day supply	
<input type="checkbox"/> Humira (adalimumab)	<input type="checkbox"/> Citrate-free Crohn's Starter Kit (3 pens)	<input type="checkbox"/> Adult Loading Dose: Inject 160mg subcutaneously on day 1, then 80mg on day 15.	1 kit	
	<input type="checkbox"/> Crohn's Starter Kit (6 pens)			
	<input type="checkbox"/> Citrate-free Crohn's Pediatric Starter Kit (2 prefilled syringes)	<input type="checkbox"/> Pediatric 6 years and older, 17 to < 40 kg Loading Dose: Inject 80mg subcutaneously on day 1, then 40mg on day 15.	1 kit	
	<input type="checkbox"/> Crohn's Pediatric Starter Kit (3 prefilled syringes)			
	<input type="checkbox"/> Citrate-free Crohn's Pediatric Starter Kit (3 prefilled syringes)			
<input type="checkbox"/> Crohn's Pediatric Starter Kit (6 prefilled syringes)	<input type="checkbox"/> Pediatric 6 years and older, ≥ 40 kg Loading Dose: Inject 160mg subcutaneously on day 1, then 80mg on day 15.	1 kit		
<input type="checkbox"/> 40mg/0.4 mL Citrate-free Pen <input type="checkbox"/> 40mg/0.8 mL Pen <input type="checkbox"/> 40mg/0.4 mL Citrate-free Prefilled Syringe <input type="checkbox"/> 40mg/0.8 mL Prefilled Syringe	<input type="checkbox"/> Adult or Pediatric 6 years or older, ≥ 40 kg Maintenance Dose: Inject 40mg subcutaneously on day 29 then every OTHER week thereafter.	28-day supply		
<input type="checkbox"/> 20mg/0.2 mL Citrate-free Prefilled Syringe <input type="checkbox"/> 20mg/0.4 mL Prefilled Syringe				
<input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Inflectra (infliximab-dyyb)	100mg Vial	<input type="checkbox"/> Loading Dose: Administer _____mg (at _____mg/kg) intravenously at 0, 2 and 6 weeks.	42-day supply	
		<input type="checkbox"/> Maintenance Dose: Administer _____mg (at _____mg/kg) intravenously every _____weeks.	28-day supply	

Prescription information continued on next page

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Simponi (golimumab)	<input type="checkbox"/> 100mg/mL SmartJect	<input type="checkbox"/> Loading Dose: Inject 200mg (two 100mg injections) subcutaneously at week 0, then 100mg at week 2, followed by maintenance dose.	14-day supply	
	<input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 100mg subcutaneously every 4 weeks.	28-day supply	
<input type="checkbox"/> Stelara (ustekinumab)	90mg/mL Prefilled Syringe	Inject 90mg (one syringe) subcutaneously every 8 weeks.	56-day supply	
<input type="checkbox"/> Tysabri (natalizumab)	300mg/15mL Concentrate	Administer 300mg via intravenous infusion over 1 hour every 4 weeks.	28-day supply	
<input type="checkbox"/> Xeljanz (tofacitinib)	<input type="checkbox"/> 10mg	<input type="checkbox"/> Loading Dose: Take 1 tablet by mouth twice daily.	30-day supply	
	<input type="checkbox"/> 5mg	<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth twice daily.		
	<input type="checkbox"/> 10mg	<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth once daily. (5mg only)		
Other Medication Name:				

Treatment History: **New to Therapy** **Continuation of Therapy**

Crohn's Severity: Moderate Severe

Enterocutaneous/Rectovaginal Fistulas? Yes No

Does patient have serious/active infection? Yes No

Has tuberculosis been assessed? Yes No

Date assessed: _____

Results: _____

Comments: _____

Is patient at risk for Hepatitis B infection? Yes No

If Yes, has Hepatitis B been ruled out or treatment initiated? Yes No

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____

Product Substitution Permitted

Dispensed as Written

Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Ship to Patient Ship to Prescriber/Clinic Pick up at Albertsons Companies Pharmacy

Date Medication Needed: _____

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