

Date: ____/____/____ Needs by Date: _____

Language: _____ Nursing Instruction Required

Ship to: Patient MD Office

CROHN'S UC REFERRAL FORM

Prescriber's Name: _____ DEA #: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: _____ Date of Birth: ____/____/____ Gender: F M

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION

<p>DIAGNOSIS/ICD-10 CODE:</p> <p><input type="checkbox"/> Crohn's Disease: <input type="checkbox"/> K50.00 <input type="checkbox"/> K50.10 <input type="checkbox"/> K50.80 <input type="checkbox"/> K50.90</p> <p><input type="checkbox"/> Ulcerative Colitis: <input type="checkbox"/> K51.50 <input type="checkbox"/> K51.00 <input type="checkbox"/> K51.80 <input type="checkbox"/> K51.90</p> <p><input type="checkbox"/> IBS-D: K58.0</p> <p><input type="checkbox"/> Travelers' Diarrhea: A09</p> <p><input type="checkbox"/> Hepatic Encephalopathy: <input type="checkbox"/> K50.80 <input type="checkbox"/> K50.80</p> <p><input type="checkbox"/> Hepatitis B: B18.1</p> <p><input type="checkbox"/> Other ICD-10: _____</p> <p>Date of Diagnosis: _____</p>	<p>PRIOR HISTORY/FAILED MEDICATIONS:</p> <p><input type="checkbox"/> 5-ASA</p> <p><input type="checkbox"/> Corticosteroids</p> <p><input type="checkbox"/> Immunosuppressants (6-MP or other)</p> <p><input type="checkbox"/> Methotrexate</p> <p><input type="checkbox"/> Surgery</p> <p><input type="checkbox"/> Other: _____</p>	<p>PRIOR BIOLOGIC HISTORY/FAILED MEDICATIONS:</p> <table border="0"> <tr> <td style="text-align: left;">Medication:</td> <td style="text-align: left;">Dates (Start/End):</td> </tr> <tr> <td><input type="checkbox"/> Humira</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Cimzia</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Remicade</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Simponi</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td>_____</td> </tr> </table>	Medication:	Dates (Start/End):	<input type="checkbox"/> Humira	_____	<input type="checkbox"/> Cimzia	_____	<input type="checkbox"/> Remicade	_____	<input type="checkbox"/> Simponi	_____	<input type="checkbox"/> Other: _____	_____
Medication:	Dates (Start/End):													
<input type="checkbox"/> Humira	_____													
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<input type="checkbox"/> Simponi	_____													
<input type="checkbox"/> Other: _____	_____													

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
<input type="checkbox"/> CIMZIA (certolizumab pegol) <input type="checkbox"/> Starter Kit <input type="checkbox"/> 200mg prefilled syringe <input type="checkbox"/> 200mg vial	<input type="checkbox"/> Induction: Inject 400mg subcutaneously at weeks 0, 2, and 4 <input type="checkbox"/> Maintenance: Inject 400mg subcutaneously every 4 weeks	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> ENTYVIO (vedolizumab)	<input type="checkbox"/> Induction: Infuse IV 300mg, over 30 minutes at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance doses: Infuse IV 300mg, over 30 minutes every 8 weeks	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> HUMIRA (adalimumab) <input type="checkbox"/> 40mg/0.8ml pen <input type="checkbox"/> 40mg/0.8ml prefilled syringe <input type="checkbox"/> Crohn's/UC Starter Kit	<input type="checkbox"/> Induction: Inject 160mg (4 pens) subcutaneously on day 1, then 80mg (2 pens) on day 15 <input type="checkbox"/> Maintenance: Inject 40mg (1 injection) subcutaneously every other week <input type="checkbox"/> Other _____	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> REMICADE (infliximab) <input type="checkbox"/> 100mg vial	<input type="checkbox"/> Induction: IV at 5mg/kg (Dose = _____ mg) at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance: IV at 5mg/kg (Dose = _____ mg) every 8 weeks <input type="checkbox"/> Other _____	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> RELISTOR <input type="checkbox"/> 12mg/0.6ml vial <input type="checkbox"/> 12mg/0.6ml PFS <input type="checkbox"/> 8mg/0.4ml PFS	Use weight-based dosing guidelines in PI to calculate individual daily dose.	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> SIMPONI (golimumab) <input type="checkbox"/> 100mg/ml SmartJect PEN <input type="checkbox"/> 100mg/ml prefilled Syringe	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> Inject 200 mg SC at week 0, then 100 mg SC week 2 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Inject 100 mg SC every 4 weeks or <input type="checkbox"/> Other _____	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> STELARA <input type="checkbox"/> 260 mg IV (2 Vials) <input type="checkbox"/> 390 mg IV (3 Vials) <input type="checkbox"/> 520 mg IV (4 Vials)	<input type="checkbox"/> Induction Dose Starter pack IV	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> 90 mg Syringe	<input type="checkbox"/> Maintenance Dose Inject one 90 mg inj SC every 8 weeks, 8 weeks after initial IV dose	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> UCERIS 9 mg tab	<input type="checkbox"/> 1 tablet QAM	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> VIBERZI (eluxadoline) <input type="checkbox"/> 100mg tablets <input type="checkbox"/> 75mg tablets	<input type="checkbox"/> IBS with diarrhea: 100mg twice a day <input type="checkbox"/> Patients WITHOUT gallbladder: 75mg twice a day	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> XIFAXAN (rifaximin) <input type="checkbox"/> 550mg tablets	<input type="checkbox"/> Hepatic Encephalopathy: 550 mg twice a day <input type="checkbox"/> IBS with diarrhea: Inject 550 mg 3 times a day	<input type="checkbox"/> Enter quantity _____	

Physician Signature: _____ Date: _____

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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