Clear Form Print Form

CROHNS/ULCERATIVE COLITIS REFERRAL FORM

Phone: 866-209-5540 Fax: 800-878-4160

Specialized Pharmacy Services

Date: _____ Needs By: _____

Ship to: ☐Patient ☐MD Office ☐ Other: _____

PATIENT INFORMATION (PLEASE ATTACH COPY OF CARD)

Patient Name: _____
Address: _____
City, ST, Zip: _____
Phone: _____
DOB: _____ Gender ☐Male ☐Female
Last 4 digits of social: _____
Emergency Contact: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
NPI: _____
Address: _____
City, ST, Zip: _____
Phone: _____
Fax: _____
Contact Person: _____
Latex Allergy: ☐ Yes ☐ No

CLINICAL INFORMATION

Therapy: ☐ New ☐ Continuation ☐ Reauthorization

Has TB test been performed? ☐ Yes (+) ☐ (-) ☐ ☐ No

***Attach TB results, provider notes, colonoscopy, med list**

☐ **K50.00** Crohn's disease of small intestine without complications
☐ **K50.10** Crohn's disease of large intestine without complications
☐ **K50-90** Crohn's disease, unspecified, without complications
☐ **K51.80** Ulcerative colitis without complications
☐ **K51.90** Ulcerative colitis unspecified
☐ **K51.919** Ulcerative colitis
☐ **Other**: ICD-10_____
Diagnosis: _____

Prior Therapies:

☐ NSAIDS Duration _____
☐ Corticosteroids Duration _____
☐ Azathioprine Duration _____
☐ Sulfasalazine Duration _____
☐ 5-ASA Duration _____
☐ 6-MP Duration _____
☐ Remicade® Duration _____
☐ Other _____
☐ Other_____
Reason for Discontinuing_____
_____

DRUG	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Cimzia®	☐ Pre-filled Syringe ☐ Lyophilized powder	☐ **STARTER DOSE:** Inject 400mg SQ at Day 1, Day 14 & Day 28 ☐ **MAINTENANCE:** Inject 400mg SQ every 2 weeks ☐ **MAINTENANCE:** Inject 400mg SQ every 4 weeks		
☐ Humira® ☐ Citrate Free ☐ Original Form	☐ Pen ☐ Pre-filled Syringe	☐ **STARTER DOSE:** Inject 160mg SQ on Day 1, then 80mg on Day 15 ☐ **MAINTENANCE:** Inject 40mg SQ once weekly ☐ **MAINTENANCE:** 40mg SQ once every other week		
☐ Remicade® 100mg Single-Dose Vials	Dose: _____mg/kg Total dose: _____mg Dose: _____mg/kg Total dose: _____mg Pt Weight	☐ **STARTER DOSE:** Administer IV at 0, 2, and 6 weeks ☐ Other: ☐ **MAINTENANCE:** Administer IV every 8 weeks ☐ Other: _____ q weeks		
☐ Simponi®	☐ SmartJect® Pen ☐ Pre-filled Syringe	☐ **STARTER DOSE:** Inject 200 mg (2 pens) SQ at day 1, followed by 100 mg (1 pen) at week two ☐ **MAINTENANCE DOSE:** Inject 100 mg SQ every 4 weeks		
☐ Stelara®	☐ IV Infusion – 6 mg/kg ☐ Pre-filled Syringe	☐ **STARTER DOSE:** Infuse _____ mg IV x1 ☐ **MAINTENANCE:** Inject 90 mg SQ every 8 weeks		
☐ Xeljanz	☐ 10mg tablet ☐ 5mg tablet	☐ **Initiation**: Take 10mg twice a day for 8 weeks ☐ **Maintenance**: ☐ Take 5mg po twice a daily ☐ Take 10mg po twice daily		
☐ Other:	☐ Entyvio® ☐ _____	_____ _____		

☐ **Patient has received injection training** ☐ **Physician's office to provide injection training** ☐ **VitalRx to coordinate injection training**

☐ PRODUCT SUBSTITUTION PERMITTED ☐ DISPENSE AS WRITTEN

authorized VitalRx Pharmacy to act as my authorized agent to initiate and complete the prior authorization process for my patient(s), and sign any necessary forms and submit electronically on my behalf as my authorized agent including the receipt of any required authorization forms but not limited to, acquiring any necessary labs, clinic notes and/or imaging.

Prescribers Signature: _____ **Date:** _____

Revised: 10/22/2020