Phone: 845-789-5648
Fax: 845-789-4104
NCPDP 5851476
NPI: 1457297335

CROHNS & UC (A-K) REFERRAL FORM

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patien*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code **Crohn's Disease** ☐ **K50.00** ☐ **K51.50** ☐ **K50.10** ☐ **K51.80** ☐ **K50.80**
Ulcerative Colitis ☐ **K51.90** ☐ **K50.90**

☐ **Yes** ☐ **No** Active TB ruled out? Date: _____ ☐ **Yes** ☐ **No** TB/PPD Test given? Date: _____
☐ **Yes** ☐ **No** Chest X-Ray? Results_____ ☐ **Yes** ☐ **No** Hep B is ruled out / treated?

Previous Meds	Strength	Duration of Treatment	Not Tolerated	Contraindications
Methotrexate				
Pentasa				
Entocort				
Humira				
Cimzia				
Enbrel				

PRESCRIPTION

PRIOR | CURRENT TREATMENTS
☐ Azathioprine ☐ Corticosteroids ☐ 5-ASA ☐ 6-MP ☐ NSAIDS ☐ Methotrexate ☐ Sulfasalazine
☐ Other _____ Dose | Duration _____

☐ **CIMZIA 200mg** ☐ **PFS** ☐ **SD Vial**
SIG: ☐ **Starting dose:** 400 mg subcutaneously initially and at weeks 2 & 4 QTY: 6 Refill: _____
☐ **Maintenance dose:** 400 mg subcutaneously every 4 weeks QTY:_____ Refill: _____

☐ **ENTYVIO 300 mg single-use 20 mL vial** Infusion supplies needed? ☐ YES ☐ NO
SIG: ☐ **Starting dose:** 300 mg infused intravenously over approximately 30 minutes on week 0, week 2 & week 6 then,
☐ **Maintenance dose:** 300 mg infused every 8 weeks QTY:_____ Refill: _____

☐ **HUMIRA STARTER KIT 80 mg/0.8mL** ☐ **PFS** ☐ **Pens**
SIG: ☐ **Starting dose:** Day 1: Inject 160 mg subcutaneously; Day 15: Inject 80 mg subcutaneously QTY: 3 Refill: 0
☐ **Starting dose:** Day 1: Inject 80 mg subcutaneously; Day 2 : Inject 80 mg subcutaneously;
Day 15: Inject 80 mg subcutaneously QTY: 3 Refill: 0

☐ **HUMIRA 40 mg/0.4mL** ☐ **PFS** ☐ **Pens** ☐ **HUMIRA CITRATE-FREE 40 mg/0.4mL** | ☐ **PFS** ☐ **Pens**
SIG: ☐ **Maintenance dose:** Day 29: Inject 40 mg/0.8 ml every other week
☐ Other: _____ QTY:_____ Refill: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure unde applicable law. If you are not the named addressee, you should not disseminate, distribute, o copy this fax. Please notify the sender immediately if you have received this document in erro and then destroy this document immediately.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

Phone: 845-789-5648
Fax: 845-789-4104
NCPDP 5851476
NPI: 1457297335

CROHNS & UC (L-Z) REFERRAL FORM

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patien*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code **Crohn's Disease** ☐ **K50.00** ☐ **K51.50** ☐ **K50.10** ☐ **K51.80** ☐ **K50.80**
Ulcerative Colitis ☐ **K51.90** ☐ **K50.90**

☐ **Yes** ☐ **No** Active TB ruled out? Date: _____ ☐ **Yes** ☐ **No** TB/PPD Test given? Date: _____
☐ **Yes** ☐ **No** Chest X-Ray? Results_____ ☐ **Yes** ☐ **No** Hep B is ruled out / treated?

Previous Meds	Strength	Duration of Treatment	Not Tolerated	Contraindications
Methotrexate				
Pentasa				
Entocort				
Humira				
Cimzia				
Enbrel				

PRESCRIPTION

PRIOR | CURRENT TREATMENTS ☐ Azathioprine ☐ Corticosteroids ☐ 5-ASA ☐ 6-MP ☐ NSAIDS
☐ Methotrexate ☐ Sulfasalazine ☐ Other _____ Dose | Duration _____

☐ **REMICADE 100 mg vial** ☐ MD Office Infusion Infusion supplies needed? ☐ YES ☐ NO
SIG: ☐ **Starting dose:** 5 mg/kg ____mg on week 0, week 2 & week 6 then,
☐ **Maintenance dose:** 5 mg/kg _____ mg every 8 weeks for ____ infusions
☐ Other: _____ QTY:_____ Refill: _____

Ulcerative Colitis only ☐ **SIMPONI** ☐ **SmartJect™** ☐ **PFS**
SIG: ☐ **Starting dose**: 200 mg subcutaneously at week 0, then 100 mg subcutaneously at week 2 QTY: 3 (100 mg/mL)
☐ **Maintenance dose**: 100 mg subcutaneously every 4 weeks QTY: 1 (100 mg/mL)
☐ Other: _____ QTY:_____ Refill: _____

Crohn's Disease only ☐ **STELARA** ☐ **130 mg/26 mL SD Vial** ☐ **45mg PFS** ☐ **90mg PFS** ☐ **45mg SD Vial**
SIG: ☐ **Starting dose**: Infuse ____mg IV initially, then maintenance
☐ **Maintenance dose**: Inject 90 mg subcutaneously 8 weeks after the initial IV dose, then every 8 weeks
QTY:_____ Refill: _____

Weight of Pt (Kg)	Recmd Dosage	Vials
≤ 55 kg or less	260 mg	2
55 kg to 85 kg	390 mg	3
≥ 85 kg	520 mg	4

Ulcerative Colitis only ☐ **XELJANZ** ☐ **5 mg tablet** ☐ **10 mg tablet**
SIG: ☐ **Starting dose**: ____ mg orally twice a day with or without food for ____ weeks QTY:_____ Refill: _____
☐ **Maintenance dose**: _____ mg orally twice a day QTY:_____ Refill: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure unde applicable law. If you are not the named addressee, you should not disseminate, distribute, o copy this fax. Please notify the sender immediately if you have received this document in erro and then destroy this document immediately.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.