



SPECIALTY CARE SOLUTIONS

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E-Scripts NCPDP#3199367 NPI#1881932093

GI / Crohn's Rx Referral Form

Date Medication Needed: Ship To: Patient's Home Prescriber's Office Or Pick-up from Pharmacy Injection needed by pharmacy? Yes No

1: Patient Information
Patient Name: Birthdate: Sex: Male Female Height: Weight: lbs. kg.
Soc. Sec. #: Preferred Phone: Known Allergies:
Address: City: State: Zip:
Alternate Caregiver Name: Preferred Phone:

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Clinical Information (Please fax all pertinent clinical and lab information)
Crohn's Disease: K50.0 (Crohn's Disease of the Small Intestine) K50.1 (Crohn's Disease of the Large Intestine)
Ulcerative Colitis: K51.0 (Ulcerative Pancolitis) K51.2 (Ulcerative Procolitis) K51.3 (Ulcerative Rectosigmoiditis)
Other:
Diagnosis Date: TB Test: Yes No Neg. Test Date:
Prior Therapy Yes No Reason for Discontinuation of Therapy Approximate Start Date Approximate End Date
Comorbidities:
Concomitant Medications:
Allergies: NKDA Other:
Has the patient received their starter dose(s) /kit? Yes; Start Date No

3: Prescriber Information
Prescriber Name: DEA#: NPI#: Tax ID#:
Address: Phone: Fax:
City: State: Zip: Key Contact: Phone:

4: Prescription Information
Table with columns: Medication, Directions, Quantity, Refill. Rows include Cimzia, Humira (Adults), and Humira (Pediatrics).

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program
Patient Signature: Date:

I authorize Park Ave. Pharmacy and its representatives to act as an agent to execute Prior authorization process.
Prescriber Signature: Prescriber, please sign and date below

Substitution Permissible Date Dispense as written Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws.