PARK AVENUE PHARMACY

SPECIALTY CARE SOLUTIONS

GI / Crohn's Rx Referral Form

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E-Scripts NCPDP#3199367 NPI#1881932093

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 Intenstine) ☐ K50.1 (Crohn's Disease of the Large Intenstine)
☐ K50.8 (Crohn's Disease of Both Intenstines) ☐ K50.9 (Crohn's Disease, unspecified)

Ulcerative Colitis: ☐ K51.0 (Ulcerative Pancolitis) ☐ K51.2 (Ulcerative Procolitis) ☐ K51.3 (Ulcerative Rectosigmoiditis)
☐ K51.5 (Left Sided Colitis) ☐ K51.8 (Other Ulcerative Colitis) ☐ K51.9 (Ulcerative Colitis, unspecified)

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

§ Cimzia® and Humira® are available on the Crohn's Disease/Ulcerative Colitis Enrollment Form A-R §

Medication	Directions	Quantity		Refill
☐ **Simponi® (golimumab)**	☐ Inject 200 mg subcut at week 0, then 100 mg at week 2	☐ 3 x 100 mg/mL	☐ SmartJect® Autoinjector ☐ PFS	0
	☐ Inject 100 mg subcut every 4 weeks	☐ 1 x 100 mg/mL	☐ SmartJect® Autoinjector ☐ PFS	_____
☐ **Stelara® (ustekinumab)**	☐ Infuse 260 mg intravenously over no less than one hour (≤55kg) ☐ Infuse 390 mg intravenously over no less than one hour (>55 kg to<85 kg) ☐ Infuse 520 mg intravenously over no less than onehour (>85 kg)	☐ 2 x 130 mg/26 mL ☐ 3 x 130 mg/26 mL ☐ 4 x 130 mg/26 mL	☐ Vials	0
	☐ Inject 90 mg subcut 8 weeks following initial intravenous dose, then every 8 weeks thereafter	☐ 1 x 90 mg/mL	☐ PFS	_____
	Date of last infusion: _____			

Injection Training Provided by: ☐Physician's Office ☐ Pharmacy ☐ Other: _____

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 Permissable _____ Date _____ Dispense as written _____ Date _____