Jersey Shore Pharmacy

CROHNS & ULCERATIVE COLITIS REFERRAL FORM

580 N. Main Street • Barnegat, NJ 08005
Phone: 609-660-1111 • Fax: 609-660-0101

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name_____ Date of Birth_____
☐ Male ☐ Female SS#_____ Language_____
Address_____ Apt #_____
City_____ State_____ ZIP_____
Phone_____ Cell_____ Email_____
Allergies_____
Ship to Patient at ☐ Home ☐ Work
OR Patient will pick up at ☐ Jersey Shore Pharmacy ☐ Physician Office

Insured's Name_____
Relation to Patient_____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare#_____
Prescription Card ☐ Yes ☐ No If Yes, Carrier_____
Phone_____ Fax_____
Policy/Group#_____
Bin#_____ Pcn#_____
RXID#_____ RX Group#_____

Diagnosis: **Crohn's Disease** ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 **Ulcerative Colitis** ☐ K51.20 ☐ K51.80 ☐ K51.90
TB/PPD Test given? ☐ Yes ☐ No Date:_____ Chest X-Ray? ☐ Yes ☐ No Results_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PATIENT TRAINING

Injection teach requested ☐ Yes ☐ No
(Injection Teaching by RN/LPN for 1-2 visits until patient is independent)
Preferred method to contact office:
☐ Phone ☐ Fax OR ☐ Email_____

PRIOR | CURRENT TREATMENTS

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

CIMZIA

☐ **Starting Dose:** 400mg SQ initially and at wks 2 & 4
☐ **Maintenance Dose:** 400 mg SQ every 4 weeks
QTY: 4 week supply Refill:_____

HUMIRA

☐ **Starting Dose:** Day 1: Inject 160mg (4 pens) SQ
Day 15: Inject 80mg (2 pens) SQ
Day 29: Maintenance
☐ **Maintenance:** Inject (1 Pen) 40mg/0.8ml every other week
☐ Other _____
QTY: 4 week supply Refill:_____

STELARA

☐ 130 mg/26 mL SD Vial
☐ 45mg PFS ☐ 90mg PFS ☐ 45mg SD Vial
☐ **Staring Dose:** Infuse _____mg IV initially, then maintenance
☐ **Maintenance Dose:** Inject 90 mg SQ 8 weeks
after the initial IV dose, then every 8 weeks
QTY:_____ Refill:_____

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

SIMPONI ® (golimumab)

☐ SmartJect™ ☐ PFS
☐ **Starting Dose:** 200mg SQ at week 0, then
100mg SQ at week 2 QTY: 3 (100 mg/mL)
Maintenance Dose:
☐ 100mg SQ every 4 weeks QTY: 1 (100 mg/mL)
☐ 50mg SQ every 4 weeks QTY: 1 (50 mg/0.5mL)
☐ Other _____
QTY:_____ Refill:_____

REMICADE 100 mg vial

☐ MD Office Infusion
Infusion supplies needed ☐ YES ☐ NO
☐ **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 every 8 weeks
☐ Other _____
QTY:_____ Refill:_____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ ZIP_____
Phone _____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

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

By signing this form and utilizing our services, you are authorizing Jersey Shore Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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