STAR CARE PHARMACY

"The First Wealth is Health"

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GASTROENTEROLOGY REFERRAL FORM

Date: _____ Attn: _____

Ship to ❒ Patient ❒ Physician Office ❒ Nurse/Training

Patient Name _____
Address _____ Suite# _____
City _____ State _____ Zip _____
Home Tel _____ Work Tel _____
Cell _____ Email _____
Date of Birth _____ SS# _____
☐ Male ☐ Female Weight _____ Height _____

Prescriber's Name _____
License# _____ DEA# _____
NPI# _____ UPIN# _____
Practice Name _____
Office Contact _____
Address _____ Suite# _____
City _____ State _____ Zip _____
Tel _____ Fax _____

Insurance Information *(Complete or attach copies of cards)*

Primary Insurance: _____
ID#: _____
Group #: _____

Insured's Name: _____
City: _____ State: _____ Phone: ( ) _____ - _____
Employer: _____

Diagnostic & Clinical Information

ICD-10 Diagnosis Code: ☐ K50.00 Crohn's Disease ☐ Other
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop taking the medication(s) before starting the new medication? ☐ Yes ☐ No
If yes, how long should patient wait before starting the new medication? _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
PPD (TB Test) ☐ Yes ☐ No Date_____

Prescription

HUMIRA® PEN CROHN'S DISEASE STARTER PKG 40MG/0.8ML
Starter Dose: ☐ Week 0 (Day 1) 160 mg SQ ☐ 40 mg SQ injections on Day 1 OR ☐ Two 40 mg SQ injections on Days 1 & 2
☐ Week 2 (Day 15): 80mg (Two 40 mg injections) SQ on Day 15 QTY: 4 wks supply (1 pack contains 6 pens) Refills: _____
☐ Alt. Dosage _____ QTY: _____ (1 pack contains 6 pens) Refills: _____

HUMIRA® MAINTENANCE THERAPY ☐ **HUMIRA® PEN** 40 mg/0.8 mL ☐ **HUMIRA® PFS** 40 mg/0.8 mL
☐ Maintenance dose (week 4+) 50 mg SQ every other week QTY: 2 Refills: _____
☐ Alt. Dosage _____ QTY: 28 days supply Refills: _____

REMICADE® ☐ 100mg Vial ☐ 5mg/kg ☐ ____mg/kg
☐ IV on weeks 0, 2 and 6 (induction) ☐ IV every 8 weeks (Maintenance Dose) ☐ IV every _____ weeks
QTY: _____# of vials Refill_____

SIMPONI™ ☐ SmartJectTM Autoinjector ☐ PFS 50mg/0.5mL
☐ Starter dose: 200mg SC at week 0, then 100mg SC at week 2 QTY: 3 (100 mg/mL)
Maintenance: ☐ 100mg SC every 4 weeks QTY: 1 (100 mg/mL) ☐ 50mg SC every 4 weeks QTY: 1 (50 mg/0.5mL)
☐ Other: _____ QTY: _____ Refill_____

☐ **APRISO 0.375g Extended Release Capsules**
☐ **CANASA 1000mg Suppository**
☐ **ENTOCORT EC Capsules 3mg**
☐ **PENTASA ☐ 250mg ☐ 500mg**
☐ **LIALDA 1.2g tablets**
☐ **DELZICOL 400mg Capsules**
☐ **UCERIS Tablets 9mg**
SIG_____
QTY_____ Refill_____

STELARA ☐ 130 mg/26 mL vial ☐ 90mg PFS
☐ STARTER: Infuse ___mg/mL on week 0 then,
☐ MAINTENANCE: Inject 90 mg SQ 8 wks after the initial IV dose, then every 8 wks.
QTY_____ Refills_____

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

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES "D A W" IN THIS BOX ☐

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