

CROHN'S DISEASE & ULCERATIVE COLITIS REFERRAL FORM

Therapy Start Date: ____ / ____ / ____ Ship To: Patient Physician 1st Fill Physician All Orders In-store Pickup

Patient Information: *Please attach FRONT and BACK copies of ALL insurance cards.*

Patient Name: _____ Date of Birth: ____ / ____ / ____ Sex: Male Female
 Social Security #: _____ Primary Phone: (____) _____ - _____ Secondary Phone: (____) _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____

Physician Information:

Physician Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: (____) _____ - _____ Fax: (____) _____ - _____ Key Contact: _____

Diagnostic Information: *Please attach recent Labs, Tests, and Clinical Notes.*

ICD-10: Crohn's Disease: K50.00, K50.10, K50.80, K50.90; K51.90 Ulcerative Colitis; K58.90 IBS; K72.90 Hepatic Encephalopathy
 ♦Has Patient received a PPD(Tuberculosis) Skin Test? Yes No ♦Result: _____
 ♦Has the patient been treated for this condition before? Yes No ♦Previous Treatment: _____
 ♦Is the patient currently on therapy? Yes No ♦Medication(s): _____
 ♦Will patient stop taking the above medication(s) before starting the new medication? Yes No
 ♦If yes, how long should they wait before starting the new medication? _____

Prescription Information:

Cimzia® 200mg/ml
 Initial dose: 400mg SQ weeks 0, 2, 4
 QTY: 6 REFILLS: 0
 Maintenance dose: 200mg SQ Q 2Wks
 Maintenance dose: 400mg SQ Q 4Wks
 QTY: _____ REFILLS: _____

Entyvio® 300mg Vial
 Initial dose: 300mg IV weeks 0, 2, 6
 QTY: 3 REFILLS: 0
 Maintenance dose: 300mg IV Q 8Wks
 QTY: _____ REFILLS: _____

Remicade® 100mg Vial
 Initial dose: _____ mg IV weeks 0, 2, 6
 QTY: _____ REFILLS: 0
 Maintenance dose: _____ mg IV
 Every _____ weeks
 QTY: _____ REFILLS: _____

Humira® 40mg/0.8ml Pen 40mg/0.8ml PFS
 Initial dose: Inject 160mg(4x40mg injections) SQ on day 1, then 80mg(2x40mg injections) SQ on day 15, then begin maintenance dose.
 QTY: 6 REFILLS: 0
 Maintenance dose: Inject 40mg SQ every other week
 QTY: _____ REFILLS: _____

Simponi®
 100mg/ml Autoinjector
 100mg/ml PFS
 Initial dose: 200mg SQ at week 0, 100mg at week 2, then start maintenance at week 6
 QTY: 3 REFILLS: 0
 Maintenance dose: 100mg SQ Q 4Wks
 Alternate Dose
 QTY: _____ REFILLS: _____

Stelara™ 130mg/26ml

Starting Dose:

Weight Range (kg)	Dosage
Up to 55 kg	<input type="checkbox"/> 260 mg (2 vials)
55 kg to 85 kg	<input type="checkbox"/> 390 mg (3 vials)
Greater than 85 kg	<input type="checkbox"/> 520 mg (4 vials)

Stelara 90mg PFS

Maintenance Dose:

90 mg SQ every 8 weeks starting 8 weeks after initial infusion dose.

QTY: _____ REFILLS: _____

Xifaxan® 550mg

BID TID

QTY: _____ REFILLS: _____

Other _____

SIG: _____

QTY: _____ REFILLS: _____

Prescriber Prior Authorization Consent: Physician hereby authorizes the Pharmacy, as agent for Physician, to perform any of the following services on behalf of Physician for this Patient: To obtain prior authorization from applicable PBMs or other payors for drugs prescribed by Physician, including, as necessary, the provision of prerequisite clinical and other patient information; to conduct benefits investigations; and to conduct eligibility investigations. In furtherance of the Pharmacy providing the above services, Physician agrees to provide or make available to the Pharmacy from time to time such information regarding patient's treatment as might be requested by payor.

I certify that I am prescribing the drug(s) listed above. I authorize the Pharmacy to perform the above services on behalf of Physician for the benefit of the Patient.

Physician's Signature: _____ DAW (Dispense as Written) **Date** ____ / ____ / ____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician

Rep: _____

Rev.: 7/25/201

CROHN'S DISEASE & ULCERATIVE COLITIS REFERRAL FORM



1517 17th Street NW, Washington DC 20036

Phone: 202-503-2644 | Fax: 202-503-1721

Our PA Team is here to help! Here is our contact information:
Main number: (202) 503-2644 | Fax number: (202) 503-1721

- To check on status of **pending PA's**, call **Angela** at ext.225

- **All other questions**, call **Dawn** at ext. 221 or **Nick** at ext. 218

❖ ***Please forward to us any updates you receive from the insurance company regarding approvals or denials***

www.grubbsnw.com

Rep: _____

Rev.: 7/25/201