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: _____ Sate: _____ 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	❑260 mg (2 vials)
55 kg to 85 kg	❑390 mg (3 vials)
Greater than 85 kg	❑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.: 9/21/2018

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GRUBB'S NW
SPECIALTY PHARMACY

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:____

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