GI Crohn's/UC Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

1. Patient Information

Patient Name: ____________________________ Birthdate: ________ Sex: ☐ Male ☐ Female Weight______________ ☐ lbs. ☐ kg
Preferred Phone: ____ Known Allergies____
Address: ____ City: ____________________ State_____________ Zip: _____________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name: ____ NPI#___________________________ Tax ID#________________________
Address: ____ Phone: _________________________ Fax: __________________________
City, State, Zip: ____ Key Contact: ____

3. Diagnosis/Clinical Information

Diagnosis:____ ICD-10: __________________

Prior Failed Medications: (medication and duration of treatment/reason for d/c)
☐ NSAID ☐ Azathioprine ☐ Cyclosporine ☐ Corticosteroids
☐ Leflunomide ☐ TNF Inhibitor ☐ 6-mercaptopurine (6MP)
☐ Oral Aminosalicylates ☐ Methotrexate
Quantiferon TB Status ☐ Positive ☐ Negative ☐ Pending

Other: ____

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
☐ Amitiza®	☐ 8 mcg tablets ☐ 24 mcg tablets	☐ Take 8 mcg by mouth twice daily ☐ Take 24 mcg by mouth twice daily	60	
☐ Cimzia®	☐ Starter Kit ☐ 200 mg Prefilled Syringe ☐ 200 mg Lyophilized Vial	☐ **Starter Dose:** Inject 400mg SC at weeks 0, 2, and 4 ☐ **Maintenance Dose:** 400mg SC every 4 weeks	1 Box 1 Box	0 _____
☐ Dificid®	☐ 200 mg tabs	☐ Take 1 tablet twice daily with or without food for 10 days	20 Tab	
☐ Lotronex®	☐ 0.5 mg ☐ 1 mg	☐ Take 0.5 mg by mouth twice daily for 4 weeks * If tolerated, but response is inadequate, may be increased after 4 weeks to 1 mg twice daily (maximum dose: 2 mg/day) ☐ Take 1 mg by mouth twice daily		
☐ Humira®	☐ Citrate-Free Starter Pack ☐ 20 mg Citrate-Free Pen ☐ 20 mg Citrate-Free Prefilled Syringe ☐ 40 mg Citrate-Free Pen ☐ 40 mg Citrate-Free Prefilled Syringe	☐ **Starter Dose**: Inject 160 mg SC day 1; 80 mg day 15; two weeks later (Day 29), then inject 40 mg SC every other week ☐ **Maintenance Dose:** Inject 40mg SC (one 40mg Pen) every other week ☐ Other: ______________________________________	1 Box _______	0 _____
☐ Xifaxan®	☐ 200 mg tabs ☐ 550 mg tabs	☐ Take _______tablets by mouth _______times per day		
☐ Simponi®	☐ 100 mg SmartJect® ☐ 100 mg Prefilled Syringe	☐ **Starter Dose**: Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 ☐ **Maintenance Dose**: 100mg SC every 4 weeks starting at week 6, after Induction dose	3 1	0 _____
☐ Stelara®	☐ 90 mg/ml Prefilled Syringe	**Starter dose**: In office infusion (infusion date: ____________) ☐ Inject 90mg SC 8 weeks after initial IV dose and then every 8 weeks thereafter	1	
☐ Uceris®	☐ 9 mg tabs	☐ Take 9 mg by mouth daily in the morning with or without food	30	
☐ Xeljanz®	☐ 5 mg Tablets	☐ Take 1 Tablet by mouth twice daily ☐ Take 2 Tablets by mouth twice daily	60 120	
☐ Other:	☐	☐		

Dispensing Options: ☐ Pick-Up | Deliver To: ☐Patient's Home ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below

.	Date .

I authorize Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.