Add Logo

EHR: select **(Add company name)** from your EHR!

CROHN'S/ UC REFERRAL FORM

Fax: (000) 000-0000
Phone: (000) 000-0000

PATIENT INFORMATION

Patient's Name:		SSN:		DOB:
Address:		City:	State:	Zip:
Home Phone:	Cell:	Height:	Weight:	Gender: Male Female
Email		Diagnosis Code:		

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

AMJEVITA™ *(adalimumab-atto)*
☐ SureClick 40 mg/0.8 mL ☐ Prefilled Syringe 20 mg/0.4 mL ☐ Prefilled Syringe 40 mg/0.8 mL
Induction: 160 mg SubQ Day 1
☐ 4 x 40 mg SubQ in one day ☐ 2 x 40 mg SubQ per day for two consecutive days
☐ 2 x 40 mg SubQ Day 15
Qty: 6 **Refills:** 0
Maintenance:
☐ 40 mg SubQ every other week
Qty: **Refills:**

CIMZIA® *(certolizumab pegol)*
☐ Prefilled Syringe ☐ Lyophilized Powder
☐ **Induction:** 400 mg (2 x 200 mg) SubQ weeks 0, 2, 4
Qty: 28 day supply **Refills:**0
Maintenance:
☐ 2 x 200 mg SubQ every 4 weeks
☐ 2 x 200 mg SubQ every 2 weeks
☐ 200 mg SubQ every 2 weeks
Qty: 28 day supply **Refills:**

DUPIXENT® *(dupilumab)*
☐ Prefilled Syringe ☐ Pen
☐ **Induction:** Inject 2 x 300 mg (600 mg) SubQ Day 1
Qty: 2 for 14 days **Refills:** None
☐ **Maintenance:** Inject 300 mg SubQ every other week
Qty: 2 for 28 days **Refills:**

Entocort® *(budesonide)*
3 mg capsules
☐ 9 mg PO daily
Qty: 90 **Refills**:

HUMIRA® *(adalimumab)*
☐ Pen ☐ Prefilled Syringe
☐ Citrate Free (CF) ☐ Original Formula
Induction:
☐ 160 mg SubQ day 1, 80 mg SubQ day 15
☐ 80 mg SubQ day 1, 80 mg SubQ day 2/ 80 mg SubQ day 15
Qty: 1 pack **Refills:** 0
☐ **Maintenance:**
40 mg SubQ every other week
Qty: 28 day supply **Refills:**
**** If dosage form is not selected, PENS will be dispensed.****

RINVOQ® *(upadacitinib)* extended-release tablets
☐ 15 mg ☐ 30 mg ☐ 45 mg
Induction:
☐ 45 mg PO once daily for 8 weeks ☐ 45 mg PO once daily for 12 weeks
Qty: 2 bottles **Refills:** 0
☐ **Maintenance:**_____ mg once daily
Qty: **Refills:**

SIMPONI® *(golimumab)*
☐ Prefilled Syringe ☐ Autoinjector
☐ **Induction:** 200 mg (2 x 100 mg) SubQ at week 0
Qty: 2 syringes **Refills:** 0

SKYRIZI™ *(risankizumab-rzaa)*
☐ OBI ☐ VIAL
☐ **Induction:** 600 mg intravenously weeks 0, 4, 8
Qty: 1 **Refills**: 0
☐ **Maintenance:**
☐ 180 mg SubQ week12, then every 8 weeks
☐ 360 mg SubQ week12, then every 8 weeks
Qty:1 **Refills:**

STELARA® *(ustekinumab)*
☐ **IV Induction:** ☐ 260 mg (pt weight: ≤ 55 kg) ☐ 390 mg (pt weight: 56-85 kg)
☐ 520 mg (pt weight: >85 kg)
Qty: **Refills:** 0
☐ **Maintenance:** Starting 8 weeks after IV induction dose, 90 mg SubQ every 8 weeks
Qty: 1

SOLESTA® *(dextranomer and sodium hyaluronate)* 1 ml Prefilled Syringe
☐ 4 submucosal injections
Qty: 4 **Refills:**

UCERIS® *(budesonide)* 9 mg Extended-Release Tablet
☐ 9 mg PO daily
Qty: 30 **Refills:**

XELJANZ® *(tofacitinib)*
☐ **Induction:** 10 mg PO twice daily for 8-16 week
Qty: **Refills:**
☐ **Maintenance:** 5 mg PO twice daily
Qty: 60 **Refills:**

XIFAXAN® *(rifaximin)* ☐ 200 mg tablet ☐ 550 mg tablet
☐ 550 mg PO three times per day for 14 days
☐ 200 mg PO three times per day for 16 days
☐ ____ mg PO ____times per day for _______ days
Qty: **Refills:**

ZEPOSIA® *(ozanimod)*
☐ 7-day titration: days 1-4: Give 0.23 mg PO once daily. days 5 to 7: Give 0.46 mg PO daily
Qty: 1 **Refills:** None
☐ **Maintenance Dosing:** Starting day 8, 0.92 mg PO once daily
Qty: 30 Refills: **Refills:**

IMMUNOSUPPRESSIVE INFUSION ☐ Biosimilar authorized
☐ **AVSOLA®** ☐ **ENTYVIO®** ☐ **INFLECTRA®** ☐ **Infliximab** ☐ **REMICADE®** ☐ **RENFLEXIS®**
☐ **Initial Dose:** ___________mg/kg at week 0, 2, and 6 ☐ **Maintenance Dose:** ________________mg/kg every 8 weeks
☐ **Other:**___________mg/kg every ____________ weeks **Refills:**____________

☐ OTHER	STRENGTH:	SIG/DIRECTIONS:	REFILLS:	QUANTITY:

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	Ship To: ☐ Patient ☐ MD Office	
NPI #:	Tax ID#:	
Prescription Signature:	Date:	

Your signature authorizes (add company name) Pharmacy Services,LLC, and their network of pharmacies, to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications We will also pursue available copay and financial assistance on behalf of your patients. ©2023 CarepathRx. All rights reserved.