## CROHN'S DISEASE/ULCERATIVE COLITIS REFERRAL FORM A-G











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Patient Name:		DOB:		Sex:	_MF
Phone:	Cell Phone:	Email Address:			
Address:			State:	Zip:	
ICD-10 Diagnosis Code:	Diagnosis:			Weight:_	
Allergies (please note reaction):  Current Medications: (list here or attach a me					Latex
Current Medications: (list here or attach a me	edication list):				
Comorbidities: (list here or attach a list):					

STRENGTH	DIRECTIONS	QUANTITY	REFILL
Starter Kit 200mg/mL Prefilled Syringe	Loading Dose: Inject 400mg (2 syringes) subcutaneously at weeks 0, 2 and 4.	1 kit (6 syringes)	
200mg/mL Prefilled Syringe	Maintenance Dose: Inject 400mg (2 syringes) subcutaneously every 4 weeks.	2 syringes	
	Loading Dose: Administer 300mg intravenously at 0, 2 and 6 weeks.	3 vials	
300mg/20mL vial	Maintenance Dose: Administer 300mg intravenously every 8 weeks.	1 vial	
Moderate aginal Fistulas? us/active infection? usessed?	Severe		
been ruled out or treatment initio	ated? Yes No		
son Name:	DEA #: NPI: Phone:		
	Email Address: City: State	e: Zip:	
bly with state specific prescription	n requirements such as e-prescribing, state specific prescription form,	fax language, etc. Nor	Date n-compliar
ti li	Prefilled Syringe  200mg/mL Prefilled Syringe  300mg/20mL vial  300mg/20mL vial  We to Therapy  Moderate aginal Fistulas? s/active infection? sessed? Results: itis B infection? been ruled out or treatment inition from Name:  Product Substitution Perform with state specific prescription	subcutaneously at weeks 0, 2 and 4.    200mg/mL	200mg/mL

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## CROHN'S DISEASE/ULCERATIVE COLITIS REFERRAL FORM H















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Patient Name:		DOB:	Sex:	М Г
Phone:	Cell Phone:	Email Address:		
Address:		Email Address: City: State:	Zip:_	
		_ Diagnosis:	Weiaht:	
Allergies (please n	ote reaction):			Latex
Garrone Modiodilo	inc. (liet riore of attach a riodication liet).			
Comorbidities: (list	t here or attach a list):			
`				
	INSURANCE INFORMATION - FAX	COPY OF PATIENT'S INSURANCE CARD - BOTH	SIDES	
MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
	Citrate-free Crohn's Starter Kit (3 pens)	Adult Loading Dose: Inject 160mg subcutaneously on day 1	1 kit	

**Prescription** 

	Crohn's Starter Kit (6 pens)	then 80mg on day 15.	I KIT				
	Citrate-free Crohn's Pediatric Starter Kit (2 prefilled syringes)  Crohn's Pediatric Starter Kit (3 prefilled syringes)	Pediatric 6 years and older, 17 to < 40 kg Loading Dose: Inject 80mg subcutaneously on day 1, then 40mg on day 15.	1 kit				
Humira (adalimumab)	Citrate-free Crohn's Pediatric Starter Kit (3 prefilled syringes)  Crohn's Pediatric Starter Kit (6 prefilled syringes)	Pediatric 6 years and older, ≥ 40 kg Loading Dose: Inject 160mg subcutaneously on day 1, then 80mg on day 15.	1 kit				
	40mg/0.4 mL Citrate-free Pen 40mg/0.8 mL Pen 40mg/0.4 mL Citrate-free Prefilled Syringe 40mg/0.8 mL Prefilled Syringe	Adult or Pediatric 6 years or older, ≥ 40 kg Maintenance Dose: Inject 40mg subcutaneously on day 29 then every OTHER week thereafter.	2 pens/ syringes				
	20mg/0.2 mL Citrate-free Prefilled Syringe 20mg/0.4 mL Prefilled Syringe	Pediatric 6 years and older, 17 to < 40 kg Maintenance Dose: Inject 20mg subcutaneously on day 29 then every OTHER week thereafter.	2 syringes				
Treatment Hi	Treatment History: New to Therapy Continuation of Therapy						
Crohn's Severity:	Moderate Severe	17					
,	ectovaginal Fistulas?	es No					
	serious/active infection?	es No					
Has tuberculosis been assessed?							
Date assessed:	Results:						
Is patient at risk for H	Hepatitis B infection?	es No					
If Yes, has Hepat	itis B been ruled out or treatment initiated?	☐ Yes ☐ No					
Prescriber Name:							
State License #:	DE	EA #: NPI:					
Additional Contact	t Person Name:						
Group or Hospital:		Phone:					
rux	E	City:State:	7ip:				
		5.5, 6.6.6.					
Prescriber Signatu	re:						
	Product Substitution Permitted	Dispensed as Written	Date				
The prescriber is to with state specific re	comply with state specific prescription requirement equirements could result in outreach to the prescr	nts such as e-prescribing, state specific prescription form, fax lanç iber.	guage, etc. Non-compliance				
Ship to Patient			eded:				

Prescriber

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## CROHN'S DISEASE/ULCERATIVE COLITIS REFERRAL FORM I-T













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Patient Name:			DOB: _			Sex:	М 🗌
Phone:	Cell Phone:			Email Address:			
Address:		City:			State:	Zip:	
ICD-10 Diagnosis Code:		_ Diagnosis:				Weight:_	
Allergies (please note reaction):		_					Latex
Current Medications: (list here or attach a	medication list):						
Comorbidities: (list here or attach a list):							

INSURANCE INFORMAT	ION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH	SIDES	
STRENGTH	DIRECTIONS	QUANTITY	REFILL
	Loading Dose: Administermg (atmg/kg) intravenously at 0, 2 and 6 weeks.		
100mg Vial	Maintenance Dose: Administermg (atmg/kg) intravenously everyweeks.		
100mg/mL SmartJect	Loading Dose: Inject 200mg (two 100mg injections subcutaneously at week 0, then 100mg at week 2, followed by maintenance dose.	3 syringes/ SmartJect	
100mg/mL Prefilled Syringe	Maintenance Dose: Inject 100mg subcutaneously every 4 weeks.	1 syringe/ SmartJect	
90mg/mL Prefilled Syringe	Inject 90mg (one syringe) subcutaneously every 8 weeks.	1 syringe	
300mg/15mL Concentrate	Administer 300mg via intravenous infusion over 1 hour every 4 weeks.	1 vial	
ctovaginal Fistulas? erious/active infection? en assessed? Results:	Yes No		
	DEA #: NPI:		
	Phone:		
	Email Address: City: State:	Zip:	
Product Substitution P	Permitted Dispensed as Written on requirements such as e-prescribing, state specific prescription form, fax lang	 Dc guage, etc. Non-col	
	STRENGTH    100mg Vial     100mg/mL SmartJect     100mg/mL Prefilled Syringe   90mg/mL Prefilled Syringe   300mg/15mL Concentrate   Story:   New to Therapy     Moderate   100mg/mL Prefilled Syringe   100mg/mL Prefilled	STRENGTH   DIRECTIONS     Loading Dose: Administermg (atmg/kg)     Intravenously at 0, 2 and 6 weeks.   mg (atmg/kg)     Intravenously everyweeks.   mg (atmg/kg)     Intravenously everymg (atmg/kg)     Intravenously	Loading Dose: Administermg (atmg/kg)

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## CROHN'S DISEASE/ULCERATIVE COLITIS REFERRAL FORM U-Z













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Prescription

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INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES				
MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
	☐ 10mg	Loading Dose: Take 1 tablet by mouth twice daily forweeks.		
Xeljanz (tofacitinib)	22mg XR	Loading Dose: Take 1 tablet (22mg) by mouth once daily forweeks.		
	5mg	Maintenance Dose: Take 1 tablet by mouth twice daily.		
	10mg	Maintenance Dose: Take 1 tablet by mouth once daily. (5mg only)	60 tablets	
	□ 11mg XR	Maintenance Dose: Take 1 tablet (11mg) by mouth once daily.	30 tablets	
Other Medication				
Name:				
Treatment His	tory: New to Therapy	□ Continuation of Therapy		
Crohn's Severity:	Moderate	Severe		
Enterocutaneous/Rec		∐Yes ∐No		
Does patient have serious/active infection? Has tuberculosis been assessed?		☐ Yes ☐ No ☐ Yes ☐ No		
Comments:	Results:			
ls patient at risk for He		Yes No		
•	is B been ruled out or treatment init	iated? Yes No		
Prescriber Name:		DEA #: NPI:		
Additional Contact F	Person Name:			
Group or Hospital: _		Phone:		
Fax:		Email Address: City: State:	7in:	
Addiess		Oity State	Zip	
Prescriber Signature	<u>):</u>			
	Product Substitution F	•		ate
The prescriber is to co with state specific rec	omply with state specific prescriptic quirements could result in outreach	on requirements such as e-prescribing, state specific prescription form, fax lang to the prescriber.	uage, etc. Non-co	mpliance
Ship to Patient	Ship to Prescriber/Clinic	Pick up at Albertsons Companies Pharmacy Date Medication Nee	eded:	

Prescriber

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