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

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
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): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia (certolizumab)	☐ 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	
☐ Entyvio (vedolizumab)	300mg/20mL vial	☐ Loading Dose: Administer 300mg intravenously at 0, 2 and 6 weeks.	3 vials	
		☐ Maintenance Dose: Administer 300mg intravenously every 8 weeks.	1 vial	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Crohn's Severity: ☐ Moderate ☐ Severe
Enterocutaneous/Rectovaginal Fistulas? ☐ Yes ☐ No
Does patient have serious/active infection? ☐ Yes ☐ No
Has tuberculosis been assessed? ☐ Yes ☐ No
Date assessed: _____ Results: _____
Comments: _____
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
If Yes, has Hepatitis B been ruled out or treatment initiated? ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

CROHN'S DISEASE/ULCERATIVE COLITIS REFERRAL FORM H

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
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): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Humira (adalimumab)	☐ Citrate-free Crohn's Starter Kit (3 pens) ☐ Crohn's Starter Kit (6 pens)	☐ Adult Loading Dose: Inject 160mg subcutaneously on day 1, then 80mg on day 15.	1 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	
	☐ 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 History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Crohn's Severity: ☐ Moderate ☐ Severe
Enterocutaneous/Rectovaginal Fistulas? ☐ Yes ☐ No
Does patient have serious/active infection? ☐ Yes ☐ No
Has tuberculosis been assessed? ☐ Yes ☐ No
Date assessed: _____ Results: _____
Comments: _____
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
If Yes, has Hepatitis B been ruled out or treatment initiated? ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

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

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
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): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb)	100mg Vial	☐ Loading Dose: Administer _____mg (at _____mg/kg) intravenously at 0, 2 and 6 weeks.		
		☐ Maintenance Dose: Administer _____mg (at _____mg/kg) intravenously every _____weeks.		
☐ Simponi (golimumab)	☐ 100mg/mL SmartJect ☐ 100mg/mL Prefilled Syringe	☐ Loading Dose: Inject 200mg (two 100mg injections subcutaneously at week 0, then 100mg at week 2, followed by maintenance dose.	3 syringes/ SmartJect	
		☐ Maintenance Dose: Inject 100mg subcutaneously every 4 weeks.	1 syringe/ SmartJect	
☐ Stelara (ustekinumab)	90mg/mL Prefilled Syringe	Inject 90mg (one syringe) subcutaneously every 8 weeks.	1 syringe	
☐ Tysabri (natalizumab)	300mg/15mL Concentrate	Administer 300mg via intravenous infusion over 1 hour every 4 weeks.	1 vial	

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Crohn's Severity: ☐ Moderate ☐ Severe
Enterocutaneous/Rectovaginal Fistulas? ☐ Yes ☐ No
Does patient have serious/active infection? ☐ Yes ☐ No
Has tuberculosis been assessed? ☐ Yes ☐ No
Date assessed: _____ Results: _____
Comments: _____
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
If Yes, has Hepatitis B been ruled out or treatment initiated? ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

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Delivery Information

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

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
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): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
	☐ 10mg ☐ 22mg XR	☐ Loading Dose: Take 1 tablet by mouth twice daily for___weeks. ☐ Loading Dose: Take 1 tablet (22mg) by mouth once daily for___weeks.		
☐ Xeljanz (tofacitinib)	☐ 5mg ☐ 10mg ☐ 11mg XR	☐ Maintenance Dose: Take 1 tablet by mouth twice daily. ☐ Maintenance Dose: Take 1 tablet by mouth once daily. (5mg only) ☐ Maintenance Dose: Take 1 tablet (11mg) by mouth once daily.	☐ 60 tablets ☐ 30 tablets	
Other Medication Name:				

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Crohn's Severity: ☐ Moderate ☐ Severe
Enterocutaneous/Rectovaginal Fistulas? ☐ Yes ☐ No
Does patient have serious/active infection? ☐ Yes ☐ No
Has tuberculosis been assessed? ☐ Yes ☐ No
Date assessed: _____ Results: _____
Comments: _____
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
If Yes, has Hepatitis B been ruled out or treatment initiated? ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
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