MORRISTOWN PHARMACY

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

5 Madison Ave #110 | Morristown, NJ, 07960

Tel: 973 - 998 - 0287 | Fax: 973 - 998 - 0288

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Last updated: May 2017

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

ICD-10 Diagnosis: Crohn's Disease ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Ulcerative Colitis ☐ K51.20 ☐ K51.80 ☐ K51.90

TB/PPD Test given? ☐ Yes ☐ No Chest X-Ray ☐ Yes ☐ No Results

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Email

Street Address Suite # City State Zip Tel Fax

License# NPI#

UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRIOR | CURRENT TREATMENTS

☐ Azathioprine ☐ Corticosteroids ☐ 5-ASA
☐ 6-MP ☐ Methotrexate ☐ NSAIDS
☐ Sulfasalazine ☐ Other

Dose | Duration

SIMPONI® (golimumab) ☐ SmartJect™ ☐ PFS

☐ 100mg SC at week 2 **QTY:** 3 (100 mg/mL)

MAINTENANCE:

☐ 100mg SC every 4 weeks **QTY:** 1 (100 mg/mL)
☐ Other

QTY Refills

CIMZIA ☐ STARTER: 400mg SQ initially and at week 2 & 4

☐ **MAINTENANCE:** 400 mg SQ every 4 weeks

QTY 4 week supply Refills

STELARA ☐ 130 mg/26 mL SD Vial ☐ 45mg PFS ☐ 90mg PFS ☐ 45mg SD Vial

☐ **STARTER:** Infuse ____mg IV initially, then maintenance
☐ **MAINTENANCE:** Inject 90 mg SQ 8 wks after the initial IV dose, then every 8 wks

QTY Refills

Weight of Patient (Kg)	Recommended Dosage	Vials
≤ 55 kg or less	260 mg	2
55 kg to 85 kg	390 mg	3
≥ 85 kg	520 mg	4

ENTYVIO 300 mg single-use 20 mL vial

Infusion supplies needed ☐ YES ☐ NO

☐ **STARTING:** 300 mg infused intravenously ove approx 30 min. on wk 0, wk 2 & wk 6 then,
☐ **MAINT:** 300 mg infused for ____ infusions every 8 wks

QTY Refills

REMICADE 100 mg vial ☐ MD Office Infusion

Infusion supplies needed ☐ YES ☐ NO

☐ **STARTING:** 5 mg/kg ____mg on week 0, week 2 & week 6 then,
☐ **MAINTENANCE:** 5 mg/kg _____ mg every 8 weeks for ____ infusions every 8 weeks
☐ Other QTY____ Refills____

HUMIRA

☐ **STARTER:** Day 1: Inject 160mg (4 pens) SQ.
Day 15: Inject 80mg (2 pens) SQ.
Day 29: maintenance
☐ **MAINT:** Inject (1 Pen) 40mg/0.8ml every other wk
☐ Other

QTY 4 week supply Refills

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) **Date**

Please fax completed form to **Morristown Pharmacy** at **973 - 998 - 0288**

Visit us at **WWWMORRISTOWNPHARMACY.COM** for online fillable forms.