CROHN'S DISEASE/ULCERATIVE COLITIS REFERRAL FORM

Phone:
Fax:
Toll Free:

Ship To: ☐ Patient ☐ Physician/Clinic ☐ Other _____ Date Shipment Needed: _____

Patient Information

Date: _____ Patient SS#: _____ ☐ Male ☐ Female
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City/County: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____ Cell Phone: _____
DOB: _____ Caregiver: _____
Height: _____ Weight: _____ Email: _____
Allergies: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Clinical

PRIOR HISTORY	PRIOR BIOLOGIC USE	PRIMARY DIAGNOSIS (ICD-9-CM)
☐ 5-ASA ☐ Immunosuppressants (6-MP or other) ☐ Corticosteroids ☐ Methotrexate ☐ Surgery ☐ Other	Date of last dose ☐ Remicade® _____ ☐ Humira® _____ ☐ Simponi® _____ ☐ Cimzia® _____	CD: ☐ 555.0 ☐ 555.1 ☐ 555.2 ☐ 555.9 UC: ☐ 556.5 ☐ 556.6 ☐ 556.8 ☐ 556.9 Date of Diagnosis: _____ Does patient have a Negative Tb test result? ☐ Yes ☐ No Date of Test: _____

Prescriber Information

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Cimzia®	☐ Cimzia Starter Kit (Prefilled Syringes) ☐ 200 mg Lyophilized Vials (LYO)	Induction Dose ☐ 400 mg Sub-Q at weeks 0, 2 and 4	☐ 1 kit=6x200 mg/mL PFS ☐ 3 cartons=6x200 mg Vials (LYO)	0
	☐ 200 mg/mL Prefilled Syringes ☐ 200 mg Lyophilized Vials (LYO)	Maintenance Dose ☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 4 weeks	☐ 1 carton=2x200 mg/mL PFS ☐ 1 carton=2x200 mg Vials (LYO)	____
☐ Humira®	☐ Humira Induction Dose ☐ Pens ☐ Prefilled Syringes (PFS)	Induction Dose ☐ 160 mg Sub-Q Day 1, 80 mg Day 15, 40mg Day 29 and every other week thereafter	☐ 1 kit=6x40 mg Pens ☐ 3 cartons=6x40 mg PFS	0
	☐ 40 mg Pens ☐ 40 mg Prefilled Syringes (PFS)	Maintenance Dose ☐ 40 mg Sub-Q every other week ☐ 40 mg Sub-Q once weekly	☐ 1 carton=2x40 mg Pens ☐ 1 carton=2x40 mg PFS ☐ 2 cartons=4x40 mg Pens ☐ 2 cartons=4x40 mg PFS	____
☐ Simponi®	☐ 100 mg/1 mL SmartJect Autoinjector	Induction Dose ☐ 200 mg Sub-Q Week 0, 100 mg Week 2 and every other week thereafter	☐ 3x100 mg SmartJect® Autoinjector ☐ 3x100 mg PFS	0
	☐ 100 mg/1 mL Prefilled Syringe	Maintenance Dose ☐ 100 mg Sub-Q every 4 weeks	☐ 1x100 mg SmartJect® Autoinjector ☐ 1x100 mg PFS	____

Cimzia Injection Training/Nurse Support:
Physician Signature required for Injection Training

Cimzia Prefilled Syringe (PFS)
☐ Office to train patient
☐ Home Health Nurse to train

Cimzia Lyophilized Powder (LYO)
☐ Office to administrator
☐ Home Health Nurse to administrator

Induction
☐ All (or)
☐ 1 (Week 0)
☐ 2 (Week 2)
☐ 3 (Week 4)

Maintenance
☐ All

Humira Injection Training/Nurse Support:
Physician Signature required for Injection Training
myHUMIRA Nurse (RN) visit to provide education and training for Sub-Q injection
☐ Patient's Home or Clinic Site
☐ Physician's Office ☐ No Nurse

Simponi Injection Training/Nurse Support: ☐ SimponiOne RN to provide education and training for Sub-Q injection ☐ No Nurse Training Needed

Complete this section ONLY if you would like _____ to initiate a Prior Authorization or Appeal on your behalf:

Prescriber Information

Physician: _____
_____
Contact Name: _____ Phone #: _____ Fax #: _____ NPI #: _____
Office Address: _____ City: _____ State: _____ Zip: _____
I authorize _____ and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
Physician's Signature: _____ DEA #: _____ Date: _____