

BERGEN AVE DRUGS CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

Specialty Pharmacy

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Today's Date

NEW PATIENT CURRENT PATIENT

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

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 over approx 30 min. on wk 0, wk 2 & wk 6 then,
 - MAINT: 300 mg infused for ____ infusions every 8 wks
- QTY _____ Refills _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

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 _____

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

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