CROHN'S & ULCERATIVE REFERRAL FORM

AccuSERV PHARMACY

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821
FAX: 877-526-8823

Start Date:

SHIP TO : ☐ Patient ☐ Office ☐ Other____

1. Patient Information:

Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: _____ Male / Female DOB: _____ Soc. Sec. #_____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Clinical Information:

Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization

Diagnosis/ ICD-10

CD: ☐ K50.0 ☐ K50.1 ☐ K50.8 ☐ K50.9

UC: ☐ K51.0 ☐ K51.2 ☐ K51.3 ☐ K51.5

Date of diagnosis;_____

Patient has negative TB test results? (yes/no)
Date of test:_____

Prior history

☐ 5-ASA ☐ Immunosuppressants (6-MP or other)
☐ Corticosteroids ☐ Methotrexate
☐ Surgery ☐ Other_____

Prior biologic use — **date of last dose**

☐ Cimzia ® _____
☐ Humira ® _____
☐ Remicade ® _____
☐ Simponi ® _____
☐ Other (please specify) _____

3. Prescription Information:

If you need a medication not listed please contact us

Medication	Strength	Directions	Quantity	Refills
☐ Cimzia®	☐ Starter Kit (PFS) ☐ 200mg vials	**Induction Dose:** ☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 kit = 6x200mg/mL PFS 3 cartons = 6x200mg ☐ Vials	
	☐ 200mg/mL PFS ☐ 200mg vials	**Maintenance Dose:** ☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 1 carton = 2x200 mg /mL PFS ☐ 1 carton = 2x200 mg vials	
☐ Entyvio®	☐ 300mg	☐ infuse intravenously over approximately 30 minutes at 0, 2, and 6 weeks, then every 8 weeks thereafter.		
☐ Humira®	☐ 40mg pens ☐ 40mg PFS	**Induction Dose:** ☐ 160 mg Sub-Q day 1, 80 mg day 15, 40 mg day 29 and every other week thereafter (adults and children ≥ 88 lb [40 kg])	☐ 1 kit = 6x40 mg pens ☐ 1 kit = 6x40 mg PFS ☐ 3 cartons = 6x40 mg PFS	
		☐ 80 mg Sub-Q day 1, 40 mg day 15, 20 mg day 29 and every other week thereafter (children < 88 lb [40kg])	Pediatric Starter Kit ☐ 1 kit = 3 x 40 mg PFS	
	☐ 40mg pens ☐ 40mg PFS ☐ 40mg PFS	**Maintenance Dose:** ☐ 40 mg Sub-Q every other week (adults and children ≥ 88 lbs [40kg]) ☐ 20 mg Sub-Q every other week (children < 88 lbs [40 kg])	☐ 1 carton = 2x40mg Pens ☐ 1 carton =2x40mg PFS ☐ 1 carton =2x20mg PFS	
☐ Remicade®	☐ 100mg vial			
☐ Simponi®	☐ 100mg Smartject Autoinjector	**Induction Dose:** ☐ 200 mg Sub-Q at week 0, 100 mg at week 2 and every 4 weeks thereafter	☐ 3 x 100 mg SmartJect Autoinjector ☐ 3 x 100 mg PFS	
	☐ 100mg/mL PFS	**Maintenance Dose:** ☐ 100 mg Sub-Q every 4 weeks	☐ 1 x 100 mg SmartJect Autoinjector ☐ 1 x 100 mg PFS	
☐ Xifaxan®	☐ 200mg tabs ☐ 550mg tabs	Take _____ tablets _____ times per day		

4. Prescriber and Shipping Information

Prescriber (print) _____ **Office Contact:**_____

Preferred method of contact: ☐ phone ☐ fax ☐ email **preferred contact persons email:**_____

Office Address:_____
(street) (city) (state) (zip)

Phone:_____ **fax:**_____ **NPI:**_____ **DEA:**_____

Prescriber's signature:_____ **Date:**_____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process (NO STAMPS)

5. Patient Support Programs (optional):

Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: **Date:**

6. Insurance Information:

Please fax a copy of the insurance card (front & back)

Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.