CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

Boro Hall Pharmacy

565 Bound Brook Road | Middlesex, NJ 08846
TEL: 732-968-0414 | FAX: 732-424-1988

FREE DELIVERY & SHIPPING TO HOME OR DOCTORS OFFICE

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient 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

STELARA ☐ 130 mg/26 mL SD Vial
☐ 45mg PFS ☐ 90 mg 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
< 55kg or less	260 mg	2
55kg 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 _____

PRIOR | CURRENT TREATMENTS
☐ Azathioprine ☐ Corticosteroids ☐ 5-ASA
☐ 6-MP ☐ Methotrexate ☐ NSAIDS
☐ Sulfasalazine ☐ Other _____
Dose | Duration _____

SIMPONI© (golimumab) ☐ SmartJect™ ☐ PFS
☐ **STARTER:** 200 mg SC at week 0, then 100 mg SC at week 2 **QTY:** 3 (100 mg/mL)
MAINTENANCE:
☐ 100 mg SC every 4 weeks **QTY:** 1 (100 mg/mL)
☐ Other _____
QTY _____ Refills _____

CIMZIA ☐ **STARTER:** 400 mg SQ initially and at week 2 & 4
☐ **MAINTENANCE:** 400 mg SQ every 4 weeks
QTY 4 week supply Refills _____

HUMIRA
☐ **STARTER:** Day 1: Inject 160mg (4 pens) SQ.
Day 15: Inject 80mg (2 pens) SQ.
Day 29: maintenance
☐ **MAINT:** Inject (1 pen) 40 mg/0.8ml every other wk
☐ Other _____
QTY 4 week supply Refills _____

REMICADE 100 mg vial ☐ MD Office Infusion
Infusion supplies needed ☐ YES ☐ NO
☐ **STARTING:** 5mg/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 ____

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

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