AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

CROHN'S DISEASE AND ULCERATIVE COLITIS REFERRAL FORM (A - R)

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description) ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Crohn's Disease ☐ K51.9 Ulcerative Colitis ☐ Other: _____

- Has patient been treated *previously* for this condition? ☐ Yes ☐ No Is patient *currently* on therapy? ☐ Yes ☐ No Please list medication(s) and treatment duration: _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No If *yes*, how long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
- Has patient received a **Quatiferon gold**, **Tspot** or **PPD (tuberculosis) Skin Test**? ☐ Yes ☐ No Date: _____ Results: ☐ Negative ☐ Positive

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** **Copay ID:**

PRESCRIPTION INFORMATION

☐ **STC Standard Protocol** will include the following: (1) dispensing ordered med / dose, (2) diluent to mix and / or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg / mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).

Cimzia® ☐ **200 mg / mL Prefilled Syringe** ☐ **200 mg Vial** ☐ **Enroll in Cimplicity™ Program**
**Cimza vial should be prepared and administered by a healthcare professional. Prefilled Syringes will be dispensed unless vial is requested.*
Starter Dose: ☐ 400 mg SQ (2 inj. of 200 mg) initially at Week 0, repeat at Weeks 2 and 4 ☐ Starter Dose Not Needed QTY: 1 Starter Kit (6 PFS) | Refills: 0
Maintenance Dose: ☐ 400 mg SQ (2 inj. of 200 mg) every 4 weeks QTY: 1 Box (2 x 200 mg) | Refills:
Alternate Dose: ☐ _____ QTY: _____ | Refills:

Entyvio® ☐ **300 mg Vial** ☐ MD's Office Infusion ☐ Home Infusion Supplies Required
Starter Dose: ☐ 300 mg IV at Week 0, Week 2, Week 6 ☐ Starter Dose Not Needed QTY: 3 Vials | Refills: 0
Maintenance Dose: ☐ 300 mg IV every 8 weeks QTY: 1 Vial | Refills:

Entyvio® ☐ **108 mg Pen** ☐ **108 mg Syringe**
Maintenance Dose: ☐ 108 mg SQ once every 2 weeks QTY: 2 Pens / Syringes | Refills:
(beginning after at least 2 IV infusions; administer in place of next scheduled IV dose and then every 2 weeks thereafter)

Humira® CF ☐ **Starter Package 80 mg / 0.8 mL Pen** *NDC: 0074-0124-03 (See Biosimilar form for alternatives)* ☐ **Enroll in Humira Complete Program**
Starter Dose: ☐ Two 80 mg SQ inj. **Day 1**, One 80 mg SQ inj. **Day 15** ☐ Starter Dose Not Needed QTY: 3 Pens | Refills: 0
☐ One 80 mg SQ inj. **Day 1**, One 80 mg SQ inj. **Day 2**, One 80 mg SQ inj. **Day 15** QTY: 3 Pens | Refills: 0

Humira® CF ☐ **40 mg / 0.4 mL Pen** *NDC: 0074-0554-02* ☐ **40 mg / 0.4 mL Prefilled Syringe** *NDC: 0074-0243-02 (See Biosimilar form for alternatives)*
Maintenance Dose: ☐ One 40 mg SQ inj. **Day 29** & every other week thereafter QTY: 2 | Refills:
Alternate Dose: ☐ _____ QTY: _____ | Refills:

Omvoh® *(CROHN'S)* ☐ MD's Office Infusion ☐ Home Infusion Supplies Required ☐ Starter Dose Not Needed
Starter Dose: ☐ **300 mg Vials:** 900 mg IV at Weeks 0, 4, and 8 QTY: 3 Vials (28 DS) | Refills: 2
Maintenance Dose: ☐ **100 mg + 200 mg:** 300 mg (2 injectors) at Week 12, then every 4 weeks thereafter _____ PEN _____ PFS QTY: 1 KIT (28 DS) | Refills:

Omvoh® *(UC)* ☐ MD's Office Infusion ☐ Home Infusion Supplies Required ☐ Starter Dose Not Needed
Starter Dose: ☐ **300 mg Vials:** 300 mg IV at Weeks 0, 4, and 8 QTY: 1 Vial (28 DS) | Refills: 2
Maintenance Dose: ☐ **100 mg:** 200 mg (2 injectors) at Week 12, then every 4 weeks thereafter _____ PEN _____ PFS QTY: 1 KIT (28 DS) | Refills:

Remicade® ☐ **Remicade® 100 mg Vial** ☐ **Inflectra® 100 mg Vial** ☐ **Renflexis® 100 mg Vial** ☐ **Avsola® 100 mg Vial** ☐ **Enroll in AccessOneSM Program**
☐ MD's Office Infusion ☐ Home Infusion Supplies Required
Starter Dose: ☐ _____ mg IV on Week 0, Week 2, Week 6 ☐ Starter Dose Not Needed QTY: _____ | Refills: 0
Maintenance Dose: ☐ _____ mg IV every _____ weeks QTY: _____ | Refills:

Rinvoq®
Starter Dose: ☐ **45 mg Tablet:** Once daily x 8 weeks *(for Ulcerative Colitis)* ☐ Starter Dose Not Needed QTY: 28 | Refills: 1
☐ **45 mg Tablet:** Once daily x 12 weeks *(for Crohn's Disease)* QTY: 28 | Refills: 2
Maintenance Dose: ☐ **15 mg Tablet:** Once daily QTY: 30 | Refills:
☐ **30 mg Tablet:** Once daily *(alternate maintenance dose for pts. w / severe or refractory disease)* QTY: 30 | Refills:

Other: ☐ _____ QTY: _____ | Refills:

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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CROHN'S DISEASE AND ULCERATIVE COLITIS REFERRAL FORM (S - Xeljanz)

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description) ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Crohn's Disease ☐ K51.9 Ulcerative Colitis ☐ Other: _____

- Has patient been treated *previously* for this condition? ☐ Yes ☐ No Is patient *currently* on therapy? ☐ Yes ☐ No Please list medication(s) and treatment duration: _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No If *yes*, how long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
- Has patient received a **Quatiferon gold**, **Tspot** or **PPD (tuberculosis) Skin Test**? ☐ Yes ☐ No Date: _____ Results: ☐ Negative ☐ Positive

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

☐ **STC Standard Protocol** will include the following: (1) dispensing ordered med / dose, (2) diluent to mix and / or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg / mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).

Simponi® ☐ **SmartJect 100 mg / mL** ☐ **Prefilled Syringe 100 mg / mL** * *SmartJect will be dispensed unless PFS is requested.*

Starter Dose: ☐ 200 mg SQ at Week 0; 100 mg at Week 2; then start maintenance at Week 6 ☐ Starter Dose Not Needed QTY: 3 | Refills: 0
Maintenance Dose: ☐ 100 mg SQ every 4 weeks starting at Week 6 QTY: 1 | Refills:
Alternate Dose: ☐ _____ QTY: _____ | Refills:

Skyrizi® *(CROHN'S)* ☐ MD's Office Infusion ☐ Home Infusion Supplies Required

Starter Dose: ☐ **600 mg Vial:** 600 mg IV on Week 0, Week 4, Week 8 ☐ Starter Dose Not Needed QTY: 1 Vial | Refills: 2
Maintenance Dose: ☐ **360 mg On-Body Injector:** 360 mg SQ on week 12 and every 8 weeks thereafter QTY: 1 | Refills:
☐ **180 mg On-Body Injector:** 180 mg SQ on week 12 and every 8 weeks thereafter QTY: 1 | Refills:

Skyrizi® *(UC)* ☐ MD's Office Infusion ☐ Home Infusion Supplies Required

Starter Dose: ☐ **600 mg Vial:** 1200 mg IV on Week 0, Week 4, Week 8 ☐ Starter Dose Not Needed QTY: 2 Vials (28 DS) | Refills: 2
Maintenance Dose: ☐ **360 mg On-Body Injector:** 360 mg SQ on week 12 and every 8 weeks thereafter QTY: 1 (56 DS) | Refills:
☐ **180 mg On-Body Injector:** 180 mg SQ on week 12 and every 8 weeks thereafter QTY: 1 (56 DS) | Refills:

Stelara® ☐ MD's Office Infusion ☐ Home Infusion Supplies Required ☐ **Enroll in Janssen CarePath Program**

Starter Dose: ☐ **IV Infusion 130 mg / 26 mL (5 mg / mL)** — single-dose vial, weight-based ☐ Starter Dose Not Needed
☐ ≤ 55 kg: IV Infusion 260 mg (2 Vials) once QTY: 2 | Refills: 0
☐ > 55 kg to 85 kg: IV Infusion 390 mg (3 Vials) once QTY: 3 | Refills: 0
☐ > 85 kg: IV Infusion 520 mg (4 Vials) once QTY: 4 | Refills: 0

Maintenance Dose: ☐ **90 mg / mL single-dose Prefilled Syringe** QTY: 1 | Refills:
☐ **Home Injection Dose:** SQ inj. 90 mg 8 weeks after first IV dose, every 8 weeks thereafter QTY: 1 | Refills:

Tremfya® ☐ MD's Office Infusion ☐ Home Infusion Supplies Required

Starter Dose: ☐ **200 mg Vial:** 200 mg IV over at least one hour at Week 0, Week 4, Week 8 ☐ Starter Dose Not Needed QTY: 1 | Refills: 2
Maintenance Dose: ☐ **100 mg Pen** ☐ **100 mg Prefilled Syringe** — Administer 100 mg SQ at Week 16, then every 8 weeks thereafter QTY: 1 | Refills:
☐ **200 mg Pen** ☐ **200 mg Prefilled Syringe** — Administer 200 mg SQ at Week 12, then every 4 weeks thereafter QTY: 1 | Refills:

Velsipity® ☐ **2 mg Tablet**
Take 1 Tablet (2 mg) by mouth once daily QTY: 30 | Refills:

Xeljanz®

Starter Dose: ☐ **10 mg Oral Tablet:** 1 Tablet PO twice daily for 8 weeks ☐ Starter Dose Not Needed QTY: 60 | Refills: 1
Other: ☐ _____ QTY: _____ | Refills:
Maintenance Dose: ☐ **5 mg Oral Tablet** ☐ **10 mg Oral Tablet** — 1 Tablet PO once daily QTY: 60 | Refills:
Other: ☐ _____ QTY: _____ | Refills:

Other: ☐ _____ QTY: _____ | Refills:

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

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CROHN'S DISEASE AND ULCERATIVE COLITIS REFERRAL FORM (Xeljanz XR - Z)

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description) ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Crohn's Disease ☐ K51.9 Ulcerative Colitis ☐ Other: _____

- Has patient been treated *previously* for this condition? ☐ Yes ☐ No Is patient *currently* on therapy? ☐ Yes ☐ No Please list medication(s) and treatment duration: _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No If *yes*, how long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
- Has patient received a **Quatiferon gold**, **Tspot** or **PPD (tuberculosis) Skin Test**? ☐ Yes ☐ No Date: _____ Results: ☐ Negative ☐ Positive

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

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PRESCRIPTION INFORMATION

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Xeljanz XR®

Starter Dose:	☐ **22 mg Oral Tablet:** 1 Tablet PO once daily for 8 weeks ☐ Starter Dose Not Needed	QTY: 30	Refills: 1
Other:	☐ _____	QTY:	Refills:
Maintenance Dose:	☐ **11 mg Oral Tablet** ☐ **22 mg Oral Tablet** — 1 Tablet PO once daily	QTY: 30	Refills:
Other:	☐ _____	QTY:	Refills:

Zeposia® ☐ **Oral Capsules** — *Directions:* **Days 1-4**: 0.23 mg by mouth once daily; **Days 5-7:** 0.46 mg by mouth once daily; **Day 8 and thereafter:** 0.92 mg by mouth once daily

New Patient:	☐ Starter Kit: 7 Day Starter Pack followed by 30 day supply	QTY: 1 Kit (37 Capsules)	Refills: 0
Patients Restarting:	☐ 7 Day Titration	QTY: 1 Kit (7 Capsules)	Refills: 0
Maintenance Dose:	☐ 0.92 mg by mouth once daily	QTY:	Refills:

Other: ☐ _____ QTY: _____ Refills: _____

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.