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	ULCERATIV	E COLITIS	REFERRAL FORM	(A-R)			
PATIENT INFORMATION					. ,			
Patient Name:	D	OB:	Sex: 🗆 N	I □ F □ Other:		Weight:	□ lbs	s. □kg.
SSN: Phone:	Al	lergies:						
Address:		(City:	State:		Zip:		
Emergency Contact:	Ph	none:			onal Informa	tion Attached		
PRESCRIBER INFORMATION								
Prescriber:	N	기:		DEA:	State Lic	:		
Supervising Physician:		F	Practice Name:					
Address:		(City:	State:		Zip:		
	Fax:	ł	Key Office Con	tact:		Phone:		
DIAGNOSIS INFORMATION / MEDICAL ASSE	SSMENT							
 Primary Diagnosis: (ICD-10 Code & Description Has patient been treated previously for this condition 								
 Will patient stop taking the above medication(s) be 	fore starting the new med	lication? Yes	No If yes, ho	w long should patient wait	before starting	the new medicatio	n?	
Other medications patient is currently taking includ	ing OTC medications with	n dosage and dire	ction (or fax med	lication profile):				
- Has patient received a Quatiferon gold, Tspot or	PPD (tuberculosis) Ski	n Test? □ Yes □	No Date:	Results: 🗆 Ne	egative 🗆 Posi	tive		
INSURANCE INFORMATION								
Please attach front and back of patient's in	nsurance card (medic	al and prescrip	otion)					
COPAY CARD ENROLLMENT								
Please check if enrolling in copay card	Copay ID:							
PRESCRIPTION INFORMATION								
□ STC Standard Protocol will include the following: (1) (for pediatric patients) and diphenhydramine 50 mg/mL) Cimzia [®] □ 200 mg/mL Prefilled Syringe □ 2) and (4) premeds to take 3				hydramine 25 r	ng, may repeat x1).	•	5 mg IM
*Cimza vial should be preared and administered by a healthcare profe Starter Dose: □ 400 mg SQ (2 inj. of 200 m Maintenance Dose: □ 400 mg SQ (2 inj. of 200 m Alternate Dose: □	essional. Prefilled Syringes will be g) initially at Week 0, rep			□ Starter Dose Not Need	ed QTY: QTY:	roll in Cimplicity™ 1 Starter Kit (6 PFS 1 Box (2 x 200 mg) Refills:	0
Entyvio [®] ☐ 300 mg Vial ☐ MD's Office Infusio Starter Dose: ☐ 300 mg IV at Week 0, Weel Maintenance Dose: ☐ 300 mg IV every 8 weeks		plies Required		Starter Dose Not Need	_	3 Vials	Refills: Refills:	0
• ,					QIT.	i vidi	Reillis.	
Entyvio [®] □ 108 mg Pen □ 108 mg Syringe Maintenance Dose: □ 108 mg SQ once every 2 w (beginning after at least 2 IV infu	eeks Isions: administer in place o	f next scheduled IV	/ dose and then e	verv 2 weeks thereafter)	QTY:	2 Pens/Syringes	Refills:	
Humira® CF Starter Package 80 mg/0.8 mL Pen NDC: 0074-0124-03 (See Biosimilar form for alternatives) Starter Dose: Two 80 mg SQ inj. Day 1, One 80 mg SQ inj. Day 15 Starter Dose Not Needed				ed QTY:		Refills:	0	
□ One 80 mg SQ inj. Day 1, 0 Humira® CF □ 40 mg / 0.4 mL Pen NDC: 0074-0554-0 Maintenance Dose: □ One 40 mg SQ inj. Day 29	2 🗆 40 mg/0.4 mL Prefi	Iled Syringe NDC		See Biosimilar form for alternati	QTY: ives) QTY:		Refills:	0
Alternate Dose:					QTY:		Refills:	
Omvoh [®] ☐ MD's Office Infusion ☐ Home Infus (CROHN'S) Starter Dose: ☐ 300 mg Vials: 900 mg IV a				□ Starter Dose Not Need		3 Vials (28 DS)	Refills:	2
Maintenance Dose: 100 mg + 200 mg: 300 mg	(2 injectors) at Week 12,	then every 4 wee	eks thereafter _	PEN PF	FS QTY:	1 KIT (28 DS)	Refills:	
Omvoh® ☐ MD's Office Infusion ☐ Home Infus (UC) Starter Dose: ☐ 300 mg Vials: 300 mg IV a	t Weeks 0, 4, and 8			Starter Dose Not Need	QTY:	1 Vial (28 DS)		2
Maintenance Dose: 100 mg: 200 mg (2 injector		-		PEN Pf		1 KIT (28 DS)	Refills:	
Remicade [®] □ Remicade [®] 100 mg Vial □ Inflect □ MD's Office Infusion □ Home Inflect	ision Supplies Required	nflexis [®] 100 mg	Vial ∐Avsola	-		oll in AccessOne	•	
Starter Dose: □ mg IV on Wee Maintenance Dose: □ mg IV every _	k 0, Week 2, Week 6 weeks			□ Starter Dose Not Need			Refills:	0
Rinvoq®					<u> </u>		1	
Starter Dose: 45 mg Tablet: Once daily 2 45 mg Tablet: Once daily 2	,	,		□ Starter Dose Not Need	ed QTY: QTY:	<u>28</u> 28	Refills: Refills:	12
Maintenance Dose: 15 mg Tablet: Once daily			· · · · · · · · · · · · · · · · · · ·		QTY:	30	Refills:	
Other:	anernate maintenance dos	se tor pts. w/ sever	e or retractory dis			30	Refills:	
						_		
Prescriber's Signature:				□ DAW (Dispense as W		Date:		
Prescriber certifies that this referral form contains an original official state prescription blank. In the event requested agent						red by law, send elect	onic prescrip	tion or on
IMPORTANT NOTICE: This message may contain privileged and conf immediately if you have received this document by mistake, then destr	idential information and is intende oy this document. Please direct a	ed only for the individua all verification or notifica	I named. If you are n ation to AcariaHealth o	ot the named addressee, you shoul or any of its subsidiaries using the c	ld not disseminate, contact information	distribute or copy this fax provided on this covershe	. Please notify et.	the sender

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Specialty	Pharmacy

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

PATIENT INFORMA	TION								
Patient Name:		DOB:	Sex: 🗆	M	er:		Weight:	□lb	s. □kg.
SSN:	Phone:	Allergies:							
Address:			City:		State:		Zip:		
Emergency Contact		Phone:			Additional	Informat	ion Attached		
PRESCRIBER INFO	RMATION								
Prescriber:		NPI:		DEA:		State Lic:			
Supervising Physicia	an:		Practice Name	9:	01.1		7:		
Address:			City:		State:		Zip:		
Phone:			Key Office Co	ntact:			Phone:		
 Primary Diagnosis Has patient been tra 	MATION / MEDICAL ASSESSMENT (ICD-10 Code & Description) K50.00 K50. eated previously for this condition? Yes No Is	s patient <i>currently</i> or	n therapy? □ Ye	s □ No Pleas	e list medication	(s) and trea			
 Will patient stop tak 	ing the above medication(s) before starting the new r		\square No If yes, i	now long should	patient wait befo	re starting	the new medication	1?	
Other medications p	patient is currently taking including OTC medications	with dosage and dir	rection (or fax me	edication profile)	:				
	d a Quatiferon gold, Tspot or PPD (tuberculosis)	Skin Test? 🗆 Yes	□No Date:	R	esults: 🗆 Negati	ve 🗆 Posit	ive		
			intion)						
	ont and back of patient's insurance card (me	dical and prescr	iption)	_		_			
COPAY CARD ENR	enrolling in copay card Copay ID:								
PRESCRIPTION IN									
	bcol will include the following: (1) dispensing ordered m	od / doso (2) diluont	to mix and / or dil	uto doco (3) fluo	has to fluch line a	und anakit n	and (oninonbring ()	3 mg IM/0	15 mg IM
	and diphenhydramine 50 mg/mL) and (4) premeds to ta							5 mg mi/ 0.	15 mg iw
	rtJect 100 mg/mL						0, , ,		
Starter Dose:	200 mg SQ at Week 0; 100 mg at Week 2; then				e Not Needed	QTY:	3	Refills:	0
	□ 100 mg SQ every 4 weeks starting at Week 6					QTY:	<u>3</u> 1	Refills:	
Alternate Dose:								Refills:	
Skyrizi® (CROHN'S) □ MD's	Office Infusion	d							
Starter Dose:	□ 600 mg Vial: 600 mg IV on Week 0, Week 4, We	eek 8		Starter Dos	e Not Needed		1 Vial	Refills:	2
Maintenance Dose:	· □ 360 mg On-Body Injector: 360 mg SQ on week					QTY: _	1	Refills:	
	□ 180 mg On-Body Injector: 180 mg SQ on week	k 12 and every 8 we	eks thereafter			QTY:_	1	Refills:	
Skyrizi [®] □ MD's	Office Infusion								
Starter Dose:	□ 600 mg Vial: 1200 mg IV on Week 0, Week 4, W			□ Starter Dos	e Not Needed		2 Vials (28 DS)		2
Maintenance Dose:	□ 360 mg On-Body Injector: 360 mg SQ on week						1 (56 DS)	Refills:	
	□ 180 mg On-Body Injector: 180 mg SQ on week		eks thereatter			QTY:_	1 (56 DS)	Refills:	
Stelara MD's Office Infusion Home Infusion Supplies Required Starter Dose: IV Infusion 130 mg/26 mL (5 mg/mL) — single-dose vial, weight-based						🗆 Enre	oll in Janssen Ca	ePath Pro	gram
Starter Dose:	$\Box \le 55 \text{ kg}$: IV Infusion 260 mg (2 Vials)		II-Dased		e not needed	QTY:_	2	Refills:	0
	$\square > 55 \text{ kg}$ to 85 kg: IV Infusion 390 mg (3 Vials)					QTY:		Refills:	
	\square > 85 kg: IV Infusion 520 mg (4 Vials)						4	Refills:	0
Maintenance Dose:	□ 90 mg/mL single-dose Prefilled Syringe					QTY:	1	Refills:	
	□ Home Injection Dose: SQ inj. 90 mg 8 weeks af	fter first IV dose, eve	ery 8 weeks there	eafter		QTY:	1	Refills:	
Tremfya [®] DMD's	Office Infusion	d							
Starter Dose:	□ 200 mg Vial: 200 mg IV over at least one hour a	at Week 0, Week 4, V	Week 8	Starter Dos	e Not Needed		1	Refills:	2
Maintenance Dose:	\Box 100 mg Pen \Box 100 mg Prefilled Syringe –	•					1	Refills:	
	□ 200 mg Pen □ 200 mg Prefilled Syringe —	Administer 200 mg	SQ at Week 12,	then every 4 wee	eks thereafter	QTY:_	1	Refills:	
Velsipity [®] D 2 mg Take	Tablet 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	8 weeks		Starter Dos	e Not Needed	QTY:_	60	Refills:	1
Other:						QTY:_		Refills:	
Maintenance Dose:	\Box 5 mg Oral Tablet \Box 10 mg Oral Tablet $-$ 1	Tablet PO once dai	ly			QTY: _	60	Refills:	
Other:								Refills:	
Other:						QTY:		Refills:	
1									

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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pecialty Pharmacy	□ Nu	rsing needed; Training n	eeded ► All the supplies inclu	iding syringes and needles wil	be dispensed if needed.
CROHN'S DISEASE AND	ULCERATIV	E COLITIS REFER	RAL FORM (Xelja	nz XR - Z)	
PATIENT INFORMATION					
Patient Name:	DOB:	Sex: 🗆 M 🗆	F Other:	Weight:	□lbs. □kg.
SSN: Phone:	Allergies:				
Address:	D	City:	State:	Zip:	
	Phone:			Information Attached	
PRESCRIBER INFORMATION Prescriber:	NPI:		DEA:	State Lic:	
Supervising Physician:	INF I.	Practice Name:	DEA.		
Address:		City:	State:	Zip:	
Phone: Fax:		Key Office Contact		Phone:	
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT					
 Primary Diagnosis: (ICD-10 Code & Description) □ K50.00 □ Has patient been treated previously for this condition? □ Yes □ No 					
• Will patient stop taking the above medication(s) before starting the r	new medication? □	Yes \Box No If yes, how lo	ng should patient wait befo	pre starting the new medic	ation?
Other medications patient is currently taking including OTC medicat		κ.	. ,		
Has patient received a Quatiferon gold, Tspot or PPD (tuberculo	sis) Skin Test? 🗆	Yes 🗆 No Date:	Results: 🗆 Negati	ve 🗆 Positive	
INSURANCE INFORMATION					
□ Please attach front and back of patient's insurance card	(medical and pro	escription)			
COPAY CARD ENROLLMENT Please check if enrolling in copay card Copay ID:					
Please check if enrolling in copay card Copay ID: PRESCRIPTION INFORMATION Copay ID:	_				
STC Standard Protocol will include the following: (1) dispensing order	ad mad/daaa (2) di	iluant to mix and (or dilute de	aa (2) fluchaa ta fluch lina (and analyit mad (aninanhrin	o 0.2 mg IM/0.15 mg IM
(for pediatric patients) and diphenhydramine 50 mg/mL) and (4) premeds	to take 30 mins before	ore orally (Apap 325 mg, ma	y repeat x1, and diphenhyd	ramine 25 mg, may repeat of	<1).
Xeljanz XR [®] Starter Dose: 22 mg Oral Tablet: 1 Tablet PO once daily	for 8 weeks		Starter Dose Not Needed	QTY: <u>30</u>	Refills: 1
Other: Maintenance Dose: 11 mg Oral Tablet 22 mg Oral Tablet	 — 1 Tablet PO on 	ice daily		QTY: QTY:30	Refills:
Other:	, mouth once daily:	Dave 5-7: 0.46 mg by m	outh once daily:	QTY:	Refills:
Days 1-4. 0.20 mg b			outil once daily,		
New Patient: Starter Kit: 7 Day Starter Pack followed by 3				QTY: <u>1 Kit (37 Capsı</u>	ıles) Refills: 0
Patients Restarting: 7 Day Titration				QTY: 1 Kit (7 Capsu	les) Refills: 0
Maintenance Dose: \Box 0.92 mg by mouth once daily				QTY:	Refills:
Other: 🗆				QTY:	Refills:
				Q.11.	
Prescriber's Signature:		C	DAW (Dispense as Writter	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.