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.*

| | | | QTY | Refills |
|---|---|---|---|---|
| Starter Dose: | ☐ 400 mg SQ ( 2 inj. of 200 mg ) initially at Week 0, repeat at Weeks 2 and 4 | ☐ Starter Dose Not Needed | 1 Starter Kit (6 PFS) | 0 |
| *Maintenance Dose:* | ☐ 400 mg SQ ( 2 inj. of 200 mg ) every 4 weeks | | 1 Box (2 x 200 mg) | |
| *Alternate Dose:* | ☐ ____________ | | | |

**Entyvio®** ☐ **300 mg Vial** ☐ MD's Office Infusion ☐ Home Infusion Supplies Required

| | | | QTY | Refills |
|---|---|---|---|---|
| *Starter Dose:* | ☐ 300 mg IV at Week 0, Week 2, Week 6 | ☐ Starter Dose Not Needed | 3 Vials | 0 |
| *Maintenance Dose:* | ☐ 300 mg IV every 8 weeks | | 1 Vial | |

**Entyvio®** ☐ **108 mg Pen** ☐ **108 mg Syringe**

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

**Humira® CF** ☐ **Starter Package 80 mg / 0.8 mL Pen** *NDC: 0074-0124-03 ( See Biosimilar form for alternatives )* — ☐ **Enroll in Humira Complete Program**

| | | | QTY | Refills |
|---|---|---|---|---|
| *Starter Dose:* | ☐ Two 80 mg SQ inj. **Day 1**, One 80 mg SQ inj. **Day 15** | ☐ Starter Dose Not Needed | 3 Pens | 0 |
| | ☐ One 80 mg SQ inj. **Day 1**, One 80 mg SQ inj. **Day 2**, One 80 mg SQ inj. **Day 15** | | 3 Pens | 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 )*

| | | QTY | Refills |
|---|---|---|---|
| *Maintenance Dose:* | ☐ One 40 mg SQ inj. **Day 29** & every other week thereafter | 2 | |
| *Alternate Dose:* | ☐ ____________ | | |

**Omvoh®** *( CROHN'S )* ☐ MD's Office Infusion ☐ Home Infusion Supplies Required ☐ Starter Dose Not Needed

| | | QTY | Refills |
|---|---|---|---|
| *Starter Dose:* | ☐ **300 mg Vials:** 900 mg IV at Weeks 0, 4, and 8 | 3 Vials ( 28 DS ) | 2 |
| *Maintenance Dose:* | ☐ **100 mg + 200 mg:** 300 mg ( 2 injectors ) at Week 12, then every 4 weeks thereafter _______ PEN _______ PFS | 1 KIT ( 28 DS ) | |

**Omvoh®** *( UC )* ☐ MD's Office Infusion ☐ Home Infusion Supplies Required ☐ Starter Dose Not Needed

| | | QTY | Refills |
|---|---|---|---|
| *Starter Dose:* | ☐ **300 mg Vials:** 300 mg IV at Weeks 0, 4, and 8 | 1 Vial ( 28 DS ) | 2 |
| *Maintenance Dose:* | ☐ **100 mg:** 200 mg ( 2 injectors ) at Week 12, then every 4 weeks thereafter _______ PEN _______ PFS | 1 KIT ( 28 DS ) | |

**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

| | | | QTY | Refills |
|---|---|---|---|---|
| *Starter Dose:* | ☐ _________ mg IV on Week 0, Week 2, Week 6 | ☐ Starter Dose Not Needed | | 0 |
| *Maintenance Dose:* | ☐ _________ mg IV every _________ weeks | | | |

**Rinvoq®**

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

**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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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 ( 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.*

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

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

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

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

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

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

| | | | QTY: | Refills: |
|---|---|---|---|---|
| *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 | | 2 | 0 |
| | ☐ > 55 kg to 85 kg: IV Infusion 390 mg ( 3 Vials ) once | | 3 | 0 |
| | ☐ > 85 kg: IV Infusion 520 mg ( 4 Vials ) once | | 4 | 0 |
| *Maintenance Dose:* | ☐ **90 mg / mL single-dose Prefilled Syringe** | | 1 | |
| | ☐ **Home Injection Dose:** SQ inj. 90 mg 8 weeks after first IV dose, every 8 weeks thereafter | | 1 | |

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

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

**Velsipity®** ☐ **2 mg Tablet**

| | | QTY: | Refills: |
|---|---|---|---|
| | Take 1 Tablet ( 2 mg ) by mouth once daily | 30 | |

**Xeljanz®**

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

**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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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 ( 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

| | |
|---|---|
| ☐ **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).

**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.**

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