AcariaHealth
Specialty Pharmacy

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

Phone: 800.511.5144 • Fax: 877.541.1503

CROHN'S DISEASE AND ULCERATIVE COLITIS REFERRAL FORM R-T

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).

Remicade® ☐100 mg Vial Avsola® ☐100 mg Powder Vial Inflectra® ☐100 mg Powder Vial Renflexis® ☐100 mg Powder Vial ☐**Enroll in AccessOneSM Program**
☐MD's Office Infusion ☐Home Infusion Supplies Required *See Biosimilar form for alternatives*
☐Starter Dose:_____mg IV on Week 0, Week 2, Week 6, then _____ QTY: _____ Refills: 0
☐Maintenance Dose:_____mg IV every_____weeks QTY: _____ Refills: _____

Rinvoq® ☐Starter Dose
☐45mg once daily x 8 weeks (for ulcerative colitis) QTY: 28 Refills: 1
☐45mg tab once daily x 12 weeks (for Crohn's disease) QTY: 28 Refills: 2

Rinvoq® ☐Maintenance Dose
☐15mg tab once daily QTY: 30 Refills: _____
☐30mg tab once daily alternate maintenance dose for pts w/severe, or refractory disease QTY: 30 Refills: _____

Simponi® ☐SmartJect 100 mg/mL ☐Prefilled Syringe 100 mg/mL *SmartJect will be dispensed if no preference indicated
☐Starter Dose: 200 mg SQ at Week 0, 100 mg at Week 2, then start maintenance at Week 6 QTY: 3 Refills: 0
☐Maintenance Dose: 100 mg SQ every 4 weeks starting at Week 6 QTY: 1 Refills: _____
☐Alternate Dose:_____ QTY: _____ Refills: _____

☐ **Skyrizi®**
☐MD's Office Infusion ☐Home Infusion Supplies Required
☐Skyrizi 600mg vial Starter Dose: 600 mg IV on Week 0, Week 4, Week 8 QTY: 3 Refills: 0
☐Skyrizi 360mg On-Body Injector Maintenance Dose:360 mg SQ on week 12 and every 8 weeks thereafter QTY: 1 Refills: _____
☐Skyrizi 180mg On-Body Injector Maintenance Dose:180 mg SQ on week 12 and every 8 weeks thereafter QTY: 1 Refills: _____

☐**Stelara®** ☐**Enroll in Janssen CarePath Program**
☐Induction Dose: IV Infusion 130 mg/26 mL (5 mg/mL) single-dose vial, weight-based ☐MD's Office Infusion ☐Home Infusion Supplies Required
☐Less than or equal to 55 kg: IV Infusion 260 mg (2 vials) once QTY: 2 Refills: 0
☐Greater than 55 kg to 85 kg: IV Infusion 390 mg (3 vials) once QTY: 3 Refills: 0
☐Greater than 85 kg: IV Infusion 520 mg (4 vials) once QTY: 4 Refills: 0
☐Maintenance Dose: 90 mg/mL single-dose Prefilled Syringe ☐Home Injection Dose: SQ inj. 90 mg 8 weeks after first IV dose, every 8 weeks thereafter QTY: 1 Refills: _____

☐**Other**:_____ QTY: _____ Refills: _____

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

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