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 PEDIATRIC REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:	Phone:		❑ **Please attach demographic information**		

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

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) ❑K50.00 ❑K50.10 ❑K50.80 ❑K50.90 Crohn's Disease ❑Other: _____

- Has patient been treated *previously* for this condition? ❑Yes ❑No 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 **PPD (tuberculosis) Skin Test or Quantiferon Tb Gold 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

❑**EpiPen®** 0.3 mg IM x1, may repeat — QTY: 2 — Refills: ____
❑**EpiPen® JR** 0.15 mg IM x1, may repeat — QTY: 2 — Refills: ____

❑**Humira® Pediatric Crohn's Starter Package CF (Ages 6-17)** — ❑**Enroll in Humira Complete Program**
- ❑17 kg to <40 kg, one 80 mg/0.8 mL and one 40 mg/0.4 mL *NDC:0074-0124-03* — QTY: ____ — Refills: ____
  Inj. SQ 80 mg on Day 1 (1 syringe), then 40 mg on Day 15 (1 syringe), then maintenance dosing
- ❑≥40 kg, three 80 mg/0.8 mL Prefilled Syringes — QTY: ____ — Refills: ____
  Inj. SQ 160 mg on Day 1 (2 syringes on Day 1), then 80 mg on Day 15 (1 syringe), then maintenance dosing

❑**Humira® Pediatric Crohn's Maintenance Dose CF (Ages 6-17)**
- ❑17 kg to <40 kg, 20 mg/0.2 mL Prefilled Syringe — QTY: ____ — Refills: ____
  Inj. SQ 20 mg on Day 29, then every other week
- ❑≥40 kg, 40 mg/0.4 mL Prefilled Syringe *NDC: 0074-0243-02* — QTY: ____ — Refills: ____
  Inj. SQ 40 mg on Day 29, then every other week
- ❑≥40 kg, 40 mg/0.4 mL Prefilled Injectable Pen *NDC: 0074-0554-02* — QTY: ____ — Refills: ____
  Inj. SQ 40 mg on Day 29, then every other week

❑**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 the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

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