RICHMOND PHARMACY
Specialty Script

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CROHN'S UC REFERRAL FORM

Date: ____/____/____ Needs by Date: __________

Language: ______________ ☐ Nursing Instruction Required

Ship to: ☐ Patient ☐ MD Office

Prescriber's Name: ______________________ DEA #: __________ NPI: __________

Address: ______________________ City, State, Zip: ______________________

Phone: __________ Fax: __________ Office Contact: __________

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: ______________________ Date of Birth: ____/____/____ Gender: ☐ F ☐ M

Address: ______________________ City, State, Zip: ______________________

Home Phone: __________ Alternate: __________ Email: __________

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION

DIAGNOSIS/ICD-10 CODE:

- ❑ **Crohn's Disease:** ❑ K50.00 ☐ K50.10 ❑ K50.80 ❑ K50.90
- ❑ **Ulcerative Colitis:** ❑ K51.50 ❑ K51.00 ❑ K51.80 ❑ K51.90
- ❑ **IBS-D:** K58.0
- ❑ **Travelers' Diarrhea:** A09
- ❑ **Hepatic Encephalopathy:** ❑ K50.80 ❑ K50.80
- ❑ **Hepatitis B:** B18.1
- ❑ **Other ICD-10:** __________

Date of Diagnosis: __________

PRIOR HISTORY/FAILED MEDICATIONS:

- ❑ 5-ASA
- ❑ Corticosteroids
- ❑ Immunosuppressants (6-MP or other)
- ❑ Methotrexate
- ❑ Surgery
- ❑ Other: __________

PRIORBIOLOGIC HISTORY/FAILED MEDICATIONS:

Medication:	Dates (Start/End):
❑ Humira	__________
❑ Cimzia	__________
❑ Remicade	__________
❑ Simponi	__________
❑ Other: __________	__________

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
☐ **CIMZIA (certolizumab pegol)** ☐ Starter Kit ☐ 200mg prefilled syringe ☐ 200mg vial	☐ Induction: Inject 400mg subcutaneously at weeks 0, 2, and 4 ☐ Maintenance: Inject 400mg subcutaneously every 4 weeks	☐ 4-Weeks supply	
☐ **ENTYVIO (vedolizumab)**	☐ Induction: Infuse IV 300mg, over 30 minutes at weeks 0, 2, and 6 ☐ Maintenance does: Infuse IV 300mg, over 30 minutes every 8 weeks	☐ Enter quantity ______	
☐ **HUMIRA (adalimumab)** ☐ 40mg/0.8ml pen ☐ 40mg/0.8ml prefilled syringe ☐ Crohn's/UC Starter Kit	☐ Induction: Inject 160mg (4 pens) subcutaneously on day 1, then 80mg (2 pens) on day 15 ☐ Maintenance: Inject 40mg (1 injection) subcutaneously every other week ☐ Other __________	☐ Enter quantity ______	
☐ **REMICADE (infliximab)** ☐ 100mg vial	☐ Induction: IV at 5mg/kg (Dose = ______ mg) at weeks 0, 2, and 6 ☐ Maintenance: IV at 5mg/kg (Dose = ______ mg) every 8 weeks ☐ Other __________	☐ Enter quantity ______	
☐ **RELISTOR** ☐ 12mg/0.6ml vial ☐ 12mg/0.6ml PFS ☐ 8mgl 0.4ml PFS	Use weight-based dosing guidelines in PI to calculate individual daily dose.	☐ Enter quantity ______	
☐ **SIMPONI (golimumab)** ☐ 100mg/ml SmartJect PEN ☐ 100mg/ml prefilled Syringe	☐ Induction Dose: ☐ Inject 200 mg SC at week 0, then 100 mg SC week 2 ☐ Maintenance Dose: ☐ Inject 100 mg SC every 4 weeks or ☐ Other __________	☐ Enter quantity ______	
☐ **STELARA** ☐ 260 mg IV (2 Vials) ☐ 390 mg IV (3 Vials) ☐ 520 mg IV (4 Vials)	☐ **Induction Dose** Starter pack IV	☐ Enter quantity ______	
☐ 90 mg Syringe	☐ **Maintenance Dose** Inject one 90 mg inj SC every 8 weeks, 8 weeks after intial IV dose	☐ Enter quantity ______	
☐ **UCERIS** 9 mg tab	☐ 1 tablet QAM	☐ Enter quantity ______	
☐ **VIBERZI (eluxadoline)** ☐ 100mg tablets ☐ 75mg tablets	☐ IBS with diarrhea: 100mg twice a day ☐ Patients WITHOUT gallbladder: 75mg twice a day	☐ Enter quantity ______	
☐ **XIFAXAN (rifaximin)** ☐ 550mg tablets	☐ Hepatic Encephelopathy: 550 mg twice a day ☐ IBS with diarrhea: Inject 550 mg 3 times a day	☐ Enter quantity ______	

Physician Signature: ______________________ Date: ______________________

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

For additional information please visit our website **www.RichmondSpecialty.com**

ePrescribe to our pharmacy "Richmond Pharmacy Specialty" • **(718) 818-2178**