CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

130 Summer Ave, Newark, NJ 07104
TEL: 973-350-6155 | FAX: 973-556-1560

Today's Date

☐ **CURRENT PATIENT**
☐ **NEW PATIENT**

July 2017

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Diagnosis: Crohn's Disease: ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90
Ulcerative Colitis: ☐ K51.20 ☐ K51.80 ☐ K51.90

TB/PPD Test given? ☐ Yes ☐ No Date:_____ Chest X-Ray? ☐ Yes ☐ No Results_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PATIENT TRAINING
Injection teach requested ☐ Yes ☐ No
(Injection Teaching by RN/LPN for 1-2 visits until patient is independent)
Preferred method to contact office:
☐ Phone ☐ Fax OR ☐ Email _____

PRIOR | CURRENT TREATMENTS
☐ Azathioprine ☐ Corticosteroids
☐ 5-ASA ☐ 6-MP ☐ NSAIDS
☐ Methotrexate ☐ Sulfasalazine
☐ Other _____
Dose | Duration _____

CIMZIA
☐ **STARTER:** 400mg SQ initially and at week 2 & 4
☐ **MAINTENANCE:** 400 mg SQ every 4 weeks
QTY: 4 week supply Refills:_____

ENTYVIO 300mg
☐ **STARTER:** Infuse 300mg IV at weeks 0, 2, & 6 then maintenance QTY: 3
☐ **MAINTENANCE:** Infuse 300 mg IV every 8 weeks
QTY_____ Refills_____

HUMIRA
☐ **STARTER:** Day 1: Inject 160mg (4 pens) SQ
Day 15: Inject 80mg (2 pens) SQ
Day 29: maintenance
☐ **MAINT.:** Inject (1 Pen) SQ 40mg/0.8ml every other week
☐ Other _____
QTY 4 week supply Refills_____

REMICADE 100 mg vial
☐ MD Office Infusion
Infusion supplies needed ☐ YES ☐ NO
☐ **STARTING:** 5 mg/kg ____mg on weeks 0, 2 & 6 then,
☐ **MAINTENANCE:** 5 mg/kg _____ mg
every 8 weeks for ____ infusions every 8 weeks
☐ Other _____
QTY_____ Refills:_____

SIMPONI (golimumab)
☐ SmartJect™ ☐ PFS
☐ **STARTER:** 200mg SQ at week 0, then
100mg SQ at week 2 **QTY:** 3 (100 mg/mL)
MAINTENANCE:
☐ 100mg SQ every 4 weeks **QTY:** 1 (100 mg/mL)
☐ 50mg SQ every 4 weeks **QTY:** 1 (50 mg/0.5mL)
☐ Other _____
QTY_____ Refills_____

STELARA
☐ 130 mg/26 mL SD Vial
☐ 45mg PFS ☐ 90mg PFS ☐ 45mg SD Vial
☐ **STARTER:** Infuse ____mg IV initially, then maintenance
☐ **MAINTENANCE:** Inject 90 mg SQ 8 wks after the initial IV dose, then every 8 wks
QTY_____ Refills_____

Weight of Patient (Kg)	Recommended Dosage	Vials
≤ 55 kg or less	260 mg	2
55 kg to 85 kg	390 mg	3
≥ 85 kg	520 mg	4

OTHER _____
Sig _____
Qty _____ Refills _____

By signing this form and utilizing our services, you are authorizing Apollo Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to **Apollo Specialty Pharmacy** at **973-556-1560** Visit us at **WWW.APOLLOSPECIALTYPHARMACY.COM** for online fillable forms.

NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH CROHNS & ULCERATIVE COLITIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ❑ Patient name
- ❑ Patient Demographics (Address, Phone Number, DOB, etc…)
- ❑ Medication list and allergies
- ❑ Insurance information with RX insurance. Please include copy of card
  If the only card included is a medical card, please include local pharmacy information
- ❑ MD name/NPI/Office contact/Phone number
- ❑ Drug indicated with refills
- ❑ MD signature and date on referral form
- ❑ Recent TB test results and date
- ❑ Previous treatment
- ❑ Symptoms
- ❑ Clinical notes

Fax the requested documentation to (973) 556-1560
Direct Phone: (973) 350-6155
ApolloSpecialtyPharmacy.