


Crohn's and Ulcerative Colitis Referral Form	Century Specialty Script Fax Referral To: 877-521-5353 Phone: 800-521-3949			
Date: _____				
Patient Information	Prescriber Information			
Please complete the following or send patient demographic sheet Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA: _____ NPI #: _____ Contact Person: _____			
Insurance Information				
Primary Insurance: _____ ID#: _____ Group: _____				
Secondary Insurance: _____ ID#: _____ Group: _____				
Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____				
Medical Information (Section must be completed to process prescription) (Attach separate sheet if needed)				
Prior Authorization Insurance Number: _____				
Diagnosis - Please include diagnosis name with ICD-10 code	Therapy Details: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart			
<input type="checkbox"/> K50.00 Crohn's disease of small intestines without complications <input type="checkbox"/> K50.8 Crohn's disease of both intestines without complications <input type="checkbox"/> K50.10 Crohn's disease of large intestines without complications <input type="checkbox"/> K50.00 Crohn's disease, unspecified, without complications <input type="checkbox"/> K20.0 Eosinophilic Esophagitis <input type="checkbox"/> Other diagnosis: ICD-10 code _____ Description _____ Date of Description _____ Has a TB test been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the Patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date _____ Review Date _____	Weight _____ kg/lbs Height _____ cm/in Allergies _____ Lab Data _____ Prior Therapies _____ Concomitant Medications _____ Additional Comments _____ Injection Training Required? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescription Information				
Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/mL Vial Kit <input type="checkbox"/> 200 mg/mL Starter Ki <input type="checkbox"/> 200mg/mL prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 400mg SC at Weeks 0, 2, and 4 <input type="checkbox"/> Maintenance Dose: Inject 200mg SC every 2 weeks		
<input type="checkbox"/> Dupixent	<input type="checkbox"/> PFS with needle shield 300 mg/2 mL <input type="checkbox"/> Prefilled Pen 300 mg/2 mL	<input type="checkbox"/> Inject 300 mg Sub Q every week		
<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> Loading Dose: Inject 300mg IV over 30 minutes at Weeks 0, 2, and 6. <input type="checkbox"/> Maintenance Dose: Infuse 300mg IV over 30 minutes every 8 weeks		
<input type="checkbox"/> Humira <input type="checkbox"/> Adalimumab (biosimilar)	Starter Kits: <input type="checkbox"/> 80mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) Maintenance: <input type="checkbox"/> 40mg/0.4mL Pre-Filled Pen (Citrate Free) <input type="checkbox"/> 40mg/0.4mL Pre-Filled Syringe (Citrate Free) <input type="checkbox"/> Other: _____	Adult: <input type="checkbox"/> Loading Dose: Inject 160mg SC on Day 1, then 80mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week (starting Day 29) Pediatric (>6 years and adolescents) 17kg to < 40kg <input type="checkbox"/> Loading Dose: Inject 80mg SC on Day 1, 40mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 20mg SC every other week (starting Day 29) Pediatric (>6 years and adolescents) > 40kg <input type="checkbox"/> Loading Dose: Inject 160mg SC on Day 1, 80mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week (starting Day 29)		
Prescriber Signature: _____ DAW (Dispense as Written) <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____				

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Crohn's and Ulcerative Colitis Referral Form

Century Specialty Script
 Fax Referral To: 877-521-5353
 Phone: 800-521-3949



Date: _____

Patient Information

Please complete the following or send patient demographic sheet
 Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 DOB: _____ Gender: M F

Prescriber Information

Prescriber Name: _____
 Address: _____ City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA: _____ NPI#: _____
 Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
 Secondary Insurance: _____ ID#: _____ Group: _____
 Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Medical Information (Section must be completed to process prescription)

(Attach separate sheet if needed)

Prior Authorization Insurance Number: _____

Diagnosis - Please include diagnosis name with ICD-10 code

- K50.00 Crohn's disease of small intestines without complications
 - K50.8 Crohn's disease of both intestines without complications
 - K50.10 Crohn's disease of large intestines without complications
 - K50.00 Crohn's disease, unspecified, without complications
 - Other diagnosis: ICD-10 code _____
- Description _____ Date of Description _____
 Has a TB test been performed? Yes No
 Does the Patient have an active infection? Yes No
 Start Date _____ Review Date _____

Therapy Details: New Reauthorization Restart

Weight _____ kg/lbs Height _____ cm/in
 Allergies _____ Lab Data _____ Prior Therapies _____
 Concomitant Medications _____
 Additional Comments _____
 Injection Training Required? Yes No

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Loading Dose: Infuse 5mg/kg at Weeks 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: Infuse 5mg/kg every 8 weeks		
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> Induction Therapy – 45 mg tablet <input type="checkbox"/> Maintenance Therapy – 15 mg or 30 mg tablets	<input type="checkbox"/> Induction Therapy: 45 mg PO daily x 8 weeks. Maintenance Therapy: <input type="checkbox"/> 15 mg PO daily <input type="checkbox"/> 30 mg PO daily		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100mg/mL Smart Ject Auto Injector <input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 200 mgSQ at Week 0 then 100mg at Week 2 <input type="checkbox"/> Maintenance Dose: Inject 100mg SQ every 4 weeks		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg/26mL solution single dose vial <input type="checkbox"/> 90mg/mL Prefilled Syringe Date of Initial Infusion: _____	<input type="checkbox"/> Loading Dose: Infuse: <input type="checkbox"/> 250mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg as initial IV dose as directed by prescriber <input type="checkbox"/> Maintenance Dose: Inject 90mg SC every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> Initiation Therapy – 600 mg/10 mL single use vial. <input type="checkbox"/> Ongoing Therapy – 360 mg/2.4 mL prefilled cartridge with On-Body Injector	<input type="checkbox"/> Initiation Therapy – <input type="checkbox"/> Inject 600 mg IV over at least 1 hour at Weeks 0, 4, 8. 1 vial/week. <input type="checkbox"/> Ongoing Therapy – Week 12 – Inject 360 mg SC and every 8 weeks thereafter. 1 device with prefilled cartridge.		
<input type="checkbox"/> Tremfya	Subcutaneous Injection: <input type="checkbox"/> 100 mg/mL in a single-dose One-Press patient-controlled injector <input type="checkbox"/> 200 mg/2 mL in a single-dose prefilled pen (Tremfya Pen) <input type="checkbox"/> 100 mg/mL in a single-dose prefilled syringe <input type="checkbox"/> 200 mg/2 mL in a single-dose prefilled syringe Intravenous Infusion: <input type="checkbox"/> 200 mg/20 mL (10 mg/mL) solution in a single-dose vial	Induction: <input type="checkbox"/> 200 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, Week 8 Maintenance: <input type="checkbox"/> 100 mg administered by subcutaneous injection at Week 16, and every 8 Week thereafter, or 200 mg administered by subcutaneous injection at Week 12, and every 4 Weeks thereafter. Use the lowest effective recommended dosage to maintain therapeutic response.		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet <input type="checkbox"/> 11mgXRtablet <input type="checkbox"/> 22mgXRtablet	<input type="checkbox"/> Loading Dose: <input type="checkbox"/> 10mg twice daily for 8 weeks <input type="checkbox"/> XR: 22mg once for 8 weeks <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 5mg twice daily <input type="checkbox"/> XR: 11mg once daily <input type="checkbox"/> 10mg twice daily <input type="checkbox"/> XR: 22mg once daily		

Prescriber Signature: _____ DAW (Dispense as Written) Y N Date: _____

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