Crohn's and Ulcerative Colitis Referral Form

Date: _____

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

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)

PriorAuthorizationInsuranceNumber: _____

Diagnosis - Please include diagnosis name with ICD-10 code

☐ K50.00 Crohn's disease of small intestines without complications
☐ K50.8 Crohn's diseaseof both intestines without complications
☐ K50.10 Crohn's disease of large intestines without complications
☐ K50.00 Crohn's disease, unspecified, without complications
☐ K20.0 Eosinophilic Esophagitis
☐ 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
☐ Cimzia	☐ 200mg/mL Vial Kit ☐ 200 mg/mL Starter Ki ☐ 200mg/mL prefilled Syringe	☐ **LoadingDose:** Inject400mg SUBQ atWeeks 0, 2, and 4 ☐ **MaintenanceDose:** Inject 200mg SUBQ every2 weeks		
☐ Dupixent	☐ PFS with needle shield 300 mg/2 mL ☐ Prefilled Pen 300 mg/2 mL	☐ Inject 300 mg SUBQ every week		
☐ Entyvio	☐ 300mg vial	☐ **Loading Dose:** Inject 300mg IV over 30 minutes at Weeks 0, 2, and 6. ☐ **Maintenance Dose:** Infuse 300mg IV over 30 minutes every 8 weeks		
☐ Humira ☐ Adalimumab *(biosimilar)*	**Starter Kits:** ☐ 80mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) **Maintenance:** ☐ 40mg/0.4mL Pre-Filled Pen (Citrate Free) ☐ 40mg/0.4mLPre-FilledSyringe (Citrate Free) ☐ Other: _____	**Adult:** ☐ **Loading Dose:** Inject 160mg SUBQ on Day 1, then 80mg on Day 15 (two weeks later) ☐ **MaintenanceDose:** Inject 40mg SUBQ every other week (starting Day 29) **Pediatric (>6 years and adolescents) 17kg to < 40kg** ☐ **Loading Dose:** Inject 80mg SUBQ on Day 1, 40mg on Day 15 (two weeks later) ☐ **Maintenance Dose:** Inject20mg SUBQ every other week (starting Day 29) **Pediatric (>6 years and adolescents) > 40kg** ☐ **Loading Dose:** Inject 160mg SUBQ on Day 1, 80mg on Day 15 (two weeks later) ☐ **MaintenanceDose:** Inject 40mg SUBQ every other week (starting Day 29)		

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

Crohn's and Ulcerative Colitis Referral Form

Date: _____

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

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
☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ 100mg Vial	☐ **Loading Dose:** Infuse 5mg/kg at Weeks 0, 2, and 6 ☐ **Maintenance Dose:** Infuse 5mg/kg every 8 weeks		
☐ Rinvoq	☐ **Induction Therapy** – 45 mg tablet ☐ **Maintenance Therapy** – 15 mg or 30 mg tablets	☐ **Induction Therapy:** 45 mg PO daily x 8 weeks. **Maintenance Therapy:** ☐ 15 mg PO daily ☐ 30 mg PO daily		
☐ Simponi	☐ 100mg/mL Smart Ject Auto Injector ☐ 100mg/mL Prefilled Syringe	☐ **Loading Dose:** Inject 200 mg SUBQ at Week0 then 100mg at Week 2 ☐ **Maintenance Dose:** Inject 100mg SUBQ every 4 weeks		
☐ Stelara	☐ 130mg/26mL solution single dose vial ☐ 90mg/mL Prefilled Syringe Date of Initial Infusion: _____	☐ **Loading Dose:** Infuse: ☐ 260mg ☐ 390mg ☐ 520mg as initial IV dose as directed by prescriber ☐ **Maintenance Dose:** Inject 90mg SUBQ every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
☐ Skyrizi	☐ **Initiation Therapy** – 600 mg/10 mL single use vial. **Ongoing Therapy**: ☐ 180 mg/1.2 mL prefilled cartridge with On-Body Injector ☐ 360 mg/2.4 mL prefilled cartridge with On-Body Injector	☐ **Initiation Therapy** – ☐ Inject 600 mg IV over at least 1 hour at Weeks 0, 4, 8. 1 vial/week. ☐ **Ongoing Therapy** - Week 12 - Inject 180mg or 360mg SUBQ and every 8 weeks thereafter. 1 device with prefilled cartridge.		
☐ Tremfya	**Subcutaneous Injection:** ☐ 100 mg/mL in a single-dose One-Press patient-controlled injector ☐ 200 mg/2 mL in a single-dose prefilled pen (Tremfya Pen) ☐ 100 mg/mL in a single-dose prefilled syringe ☐ 200 mg/2 mL in a single-dose prefilled syringe **Intravenous Infusion:** ☐ 200 mg/20 mL (10 mg/mL) solution in a single-dose vial	**Induction:** ☐ 200 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, Week 8 **Maintenance**: ☐ 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.		
☐ Xeljanz	☐ 5mg tablet ☐ 10mg tablet ☐ 11mg XR tablet ☐ 22mg XR tablet	☐ **Loading Dose:** ☐ 10mg twice daily for 8 weeks ☐ XR: 22mg once for 8 weeks ☐ **Maintenance Dose:** ☐ 5mg twice daily ☐ XR: 11mg once daily ☐ 10mg twice daily ☐ XR: 22mg once daily		

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