CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

Date: _____
☐ Current Patient ☐ New Patient

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

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

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

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

DIAGNOSIS & CLINICAL ASSESSMENT *(Fill in below or attach lab work)*

☐ New to Therapy ☐ Currently on Therapy | Start Date: _____ ☐ Physician Provides Injection Training | Injection Date: _____

TB Test Results(Please provide copy of result) & Date: _____ **Current Weight**: _____ **Date**: _____
Allergies: _____

☐ Inadequate Response to Conventional Treatment: _____ ☐ Has the Patient received Starter Dose Kit (Date):_____

Clinical Information (Please fax all pertinent clinical and lab information)

Crohn's Disease:

- ☐ K50.0 (Crohn's Disease of the Small Intenstine)
- ☐ K50.1 (Crohn's Disease of the Large Intenstine
- ☐ K50.8 (Crohn's Disease of Both Intenstines)
- ☐ K50.9 (Crohn's Disease, unspecified)

Ulcerative Colitis:

- ☐ K51.0 (Ulcerative Pancolitis)
- ☐ K1.2 (Ulcerative Procolitis)
- ☐ K1.3 (Ulcerative Rectosigmoiditis)
- ☐ K51.5 (Left Sided Colitis)
- ☐ K1.8 (Other Ulcerative Colitis)
- ☐ K1.9 (Ulcerative Colitis, unspecified)

Other: _____

Cimzia® (certolizumab pegol)

☐ Starter Kit (6) 200mg Prefilled Syringes
☐ 2 x 200mg Vials
☐ 2 x 200mg Prefilled Syringes
Dose / Directions / Frequency:
☐ Induction Dose: 2 x 200mg injections at Week 0, 2 and 4
☐ Maintenance Dose: 400 mg s-c monthly
☐ Other: _____
QTY: _____ Refill: _____

Stelara® (ustekinumab)

☐ 2 x 130mg/26mL ☐ 3 x 130mg/26mL
☐ 4 x 130mg/26mL ☐ 1 x 90mg/mL PFS
Dose / Directions / Frequency:
☐ Infuse 260mg intravenously over no less than one hour (<55kg)
☐ Infuse 390mg intravenously over no less than one hour (55kg to 85kg)
☐ Infuse 520mg intravenously over no less than one hour (>85kg)
☐ Inject 90mg SQ 8 weeks post-initial IV dose, then q 8 weeks thereafter
QTY: _____ Refill: _____

Xeljanz®

☐ Xeljanz 5mg
☐ Xeljanz 10mg

Directions:
☐ Take 1 tablet BID

Entyvio® (vedolizumab)

☐ 300 mg Vial
Dose / Directions / Frequency:
☐ Induction Dose: 300mg IV at wk 0, 2 & 6
☐ Maintenance Dose: 300mg IV every 8 wks
QTY: _____ Refill: _____

Simponi® & Simponi Aria®

Simponi:
☐ Smartject 50mg/0.5ml ☐ PFS 50mg/0.5ml
☐ Inject 50mg subcutaneously once per month
QTY: _____ Refill: _____

Simponi Aria:
☐ 50mg/4ml vial
☐ Infuse _____ mg (2mg/kg) IV over 30 minutes at weeks 0 and 4, then every 8 weeks
QTY: _____ Refill: _____

Xifaxan® (rifaximin)

☐ 550mg tablet ☐ 200mg tablet
Dose / Directions / Frequency:
☐ 1 tablet PO TID for 14 days ☐ 1 tablet PO BID ☐ 1 tablet PO TID for 3 days
QTY: _____ Refill: _____

Humira® (adalimumab)

☐ Crohn's Starter Kit, 3 x 80mg pens (C.F)
☐ Pediatric Crohn's Starter Kit, 3 x 40mg PFS
☐ 40mg Pens ☐ 40 mg PFS
☐ 20mg pediatric PFS ☐ 10mg pediatric PFS
Dose / Directions / Frequency:
☐ Induction Dose: Adults & Children >= 88lbs; 160mg (4 x 40mg injections in one day or 2 x 40mg injections per day for two consecutive days); Second dose two weeks later (Day 15) 80mg
☐ Induction dose: Children < 88lbs; 80mg (2 x 40mg injections in one day) Second dose two weeks later (Day 15) 40mg
☐ Maintenance: ____mg every other week
☐ Other: _____
QTY: _____ Refill: _____

Remicade® (infliximab)

☐ 100 mg Vial **SIG:**_____
QTY: _____ Refill: _____

Other/Notes:_____
_____
_____
_____
_____
_____

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

If Century Specialty Script is the patient's choice, please Call, Fax, Mail, or send an electronic prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353