Inflammatory Bowel Disease Referral Form

Referral for Medication and Patient Management Program

Phone: 877 385 0535 Fax: 877 326 2856

OptiMed SPECIALTY PHARMACY

V.12.13.16.A

Patient Demographics

Name: _____ ☐M ☐F

DOB: _____ SS#: _____

Phone: _____ 2nd Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary language, if other than English: _____

****Please fax a copy (front and back) of the patient's insurance card as well as any relevant clinical notes/documents****

Provider Information

Prescriber: _____

_____

Phone: _____ Fax: _____

Address: _____

_____

NPI: _____ Office contact: _____

This is a: ☐New Rx ☐Refill

Training by: ☐Prescriber's office ☐Pharmacy to facilitate ☐Not needed

Deliver first fill to: ☐Prescriber's office ☐Patient ☐Other: _____

Clinical Information

Diagnosis (ICD-10 Code):

Crohn's Disease:

- ☐ Crohn's Disease (Small Intestine) (K50.0)
- ☐ Crohn's Disease (Large Intestine) (K50.1)
- ☐ Crohn's Disease (Both Intestines) (K50.8)
- ☐ Crohn's Disease, unspecified (K50.9)
- ☐ Other: _____

Ulcerative Colitis:

- ☐ Ulcerative Pancolitis (K51.0)
- ☐ Ulcerative Proctitis (K51.2)
- ☐ Ulcerative Rectosigmoiditis (K51.3)
- ☐ Left Sided Colitis (K51.5)
- ☐ Other Ulcerative Colitis (K51.8)
- ☐ Ulcerative Colitis, Unspecified (K51.9)
- ☐ Other: _____

Date of negative TB test: _____ ☐TB test pending, will fax results

HBV negative or treated: ☐Yes ☐No

Patient weight: _____ Height: _____

Allergies: _____

Prior treatment, treatment dates, & reason for discontinuation: _____

_____

_____

_____

_____

Comorbid conditions: _____

_____

_____

Other notes: _____

_____

_____

_____

Prescription Information

Medication	Directions	Quantity	Refills
☐Cimzia 200mg (certolizumab)	☐Induction: Inject 400mg SQ week 0, week 2, and week 4.	6 syringes	Zero
	Maintenance: ☐Inject 200mg SQ every OTHER week. ☐Inject 400mg SQ every 4 weeks.	☐2 syringes ☐Other:_____	_____
☐Humira 40mg (adalimumab)	☐Induction: Inject 160mg SQ on day 1, 80mg on day 15, then 40mg every OTHER week thereafter.	☐6 pens/syringes	Zero
	☐Maintenance: Inject 40mg SQ every OTHER week. ☐Other:_____	☐2 pens/syringes ☐Other:_____	_____
☐Simponi (golimumab)	☐Induction: Inject 200mg SQ week 0, 100mg week 2, then 100mg every 4 weeks thereafter.	3 pens/syringes	Zero
	☐Maintenance: Inject 100mg SQ every 4 weeks. ☐Other:_____	☐1 pen/syringe ☐Other:_____	_____
☐Stelara (ustekinumab)	Maintenance: Inject 90mg SQ every 8 weeks, beginning 8 weeks after IV loading dose.	☐1 syringe ☐Other:_____	_____

Please note, to increase adherence and patient acceptance, all medications will be dispensed as pen-type injectors unless unavailable or otherwise specified.

Provider Signature: _____ **Date:** _____

My signature for this prescription also authorizes OptiMed Pharmacy and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process.