Crohn's & Ulcerative Colitis Referral Form

Phone: (706) 849-4161 **Fax:** (706) 798-9683

PATIENT INFORMATION (*Complete or include demographic sheet)*	**PRESCRIBER INFORMATION**
Patient Name:_____ DOB:_____	Prescriber Name: _____
Address: _____	State License #: _____ NPI#: _____
City, State, Zip:_____	DEA#: _____
Primary Phone:_____	Organization:_____
Alternate Phone:_____ Gender:_____	Address:_____
Email:_____	City, State, Zip: _____
SSN:_____	Phone: _____ Fax: _____
Allergies:_____	Contact Person: _____ Tax ID: _____

INSURANCE INFORMATION: Please fax/scan the front and back of the insurance card

DIAGNOSIS AND CLINICAL INFORMATION *(Prescriber must provide the following)*

Deliver to: □ Patient □ Office □ Other (specify): _____ Negative Tb test/PPD: □ Yes □ No Tb Test Date:_____

Diagnosis (ICD-10 code): □ Crohn's Disease _____

□ Ulcerative Colitis _____

□ Other:_____

Is Patient currently on therapy: □ Yes □ No If Yes, Medications: _____

Prior failed medications *(duration and reason for discontinuation*): _____

_____

□ Attached active medication list for pharmacist review

Injection Training/ Home Health Coordination: Expected date: _____ □ MD office □ Barney's Specialty □ Alternate program

HUMIRA® (Adalimumab) **Starter Kit** (contains six 40mg prefilled syringes) Directions: □ Inject 160 mg SC on day 1, then inject 80mg SC on day 15 **Maintenance dose** □ 40mg Kwikpen □ 40mg Prefilled syringe Directions: □ Inject 40mg SC every other week Quantity:_____ Refills:_____	SIMPONI® (Golimumab) **Starter Kit** (contains three 100mg prefilled syringes) Directions: □ Inject 200mg SC on day 1, then inject 100mg SC on day 15 **Maintenance dose** □ 100mg/ml Smartject □ 100mg/ml Prefilled syringe Directions: □ Inject 100mg SC every 4 weeks Quantity:_____ Refills:_____
CIMZIA® (Certolizumab) **Starter Kit (**contains six 200mg prefilled syringes) Directions: □ Inject 400mg (2 syringes) SC on days 1, 15, and 29 **Maintenance dose** (200mg prefilled syringe) Directions: □ Inject 400mg every 4 weeks Quantity:_____ Refills:_____	OTHER (specify): □_____ Directions: _____ Quantity:_____ Refills:_____

Patient Support Program: Please sign and date below to enroll in the pharmaceutical company assisted patient support programs and patient funding.

PATIENT SIGNATURE _____ Date: _____

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

X_____ X_____

Dispense as written Substitution Permitted