



Crohn's & Ulcerative Colitis Referral Form

Phone: (706) 849-4161

Fax: (706) 798-9683

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

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.