CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

Date: _____

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: _____

Primary Diagnosis Code & Condition: _____ **Date of Diagnosis**: _____

TB Test Results & Date: _____ **Current Weight**: _____ **Date**: _____ **Allergies**: _____

☐ New Therapy Induction ☐ Therapy Change ☐ Remicade Therapy Continuation, Weeks Completed: ☐ 0 ☐ 2 ☐ 4 ☐ 6 Date: _____

☐ Inadequate Response to Methotrexate (Dose: _____) ☐ Unresponsive to Conventional Treatment, Other Therapies: _____

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: _____

Entyvio® (vedolizumab)

☐ 300 mg Vial

Dose / Directions / Frequency:

☐ Induction Dose: 300mg IV at wk 0, 2 & 6
☐ Maintenance Dose: 300mg IV every 8 wks
☐ Other: _____

QTY: _____ Refill: _____

Simponi®

☐ Auto Injection: _____50mg ____100mg
☐ Syringe: _____50mg _____100mg

Dose / Directions / Frequency:

☐ Induction Dose: 200mg s-c initially then 100mg 2 weeks later
☐ Maintenance Dose: 100mg s-c Q 4 wks
☐ Other: _____

QTY: _____ Refill: _____

Remicade® (infliximab)

☐ 100 mg Vial **SIG:**_____

QTY: _____ Refill: _____

Humira® (adalimumab)

☐ Crohn's Starter Kit, 6 x 40mg pens
☐ 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: _____

Step Therapies: ☐ Therapy tried and failed

Therapy: _____ Date: _____
Therapy: _____ Date: _____
Therapy: _____ Date: _____

Other/Notes:_____
_____
_____

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

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