MEMORIAL HERMANN Specialty Pharmacy

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

Adult Non-Infusion Drugs

Prescriber, please sign and fax completed form to 713.704.3841
For questions, please call 281.698.6100

SHIP TO: ☐ Patient ☐ Office (1st dose) ☐ Office (All doses)

Patient Information

Please include copy of prescription and medical insurance card, front and back

Patient Name: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City, State, Zip: _____ Allergies: _____

Prescriber Information

Prescriber Name: _____ NPI: _____

Specialty: _____ Phone: _____

Office Street Address: _____ Fax: _____

City, State, Zip: _____ Office Contact: _____

Patient Medical Information

**Please include copies of any pertinent clinical notes and lab work **

Diagnosis (ICD-10):

☐ K50.0 (Crohn's Disease of the Small Intestine)
☐ K50.1 (Crohn's Disease of the Large Intestine)
☐ K50.8 (Crohn's Disease of Both Intestines)
☐ K50.9 (Crohn's Disease, unspecified)
☐ K51.0 (Ulcerative Pancolitis)
☐ K51.2 (Ulcerative Procolitis)
☐ K51.3 (Ulcerative Rectosigmoiditis)
☐ K51.5 (Left Sided Colitis)
☐ K51.8 (Other Ulcerative Colitis)
☐ K51.9 (Ulcerative Colitis, unspecified)
☐ Other _____

Diagnosis Date: _____ Date of negative TB Test: _____ Date of negative chest X-ray (if TB positive): _____

Previous and/or Current Medications Used to Treat this Diagnosis:

Medication Name(s)	Current Use	Start Date	End Date	Discontinue Reason (if stopped)
	☐			☐ Failed ☐ Other Explanation:_____
	☐			☐ Failed ☐ Other Explanation:_____
	☐			☐ Failed ☐ Other Explanation:_____

Prescription Information

		Quantity	Form	Refills
☐ **Cimzia** (certolizumab)	Initial (if applicable) ☐ Inject 400 mg subcutaneously at weeks 0, 2, and 4	☐ #6 (200 mg / 1 mL)	☐ PFS ☐ Vial	No Refills
	Maintenance ☐ Inject 400 mg subcutaneously every 4 weeks	☐ #2 (200 mg / 1 mL)	☐ PFS ☐ Vial	Refills:____
☐ **Humira** 40mg / 0.8 mL (adalimumab)	Initial (if applicable) ☐ Inject 160 mg subcutaneously on day 1 and 80 mg on day 15	☐ #6 (40 mg / 0.8 mL)	☐ Pen Starter Kit ☐ PFS	No Refills
	Maintenance ☐ Inject 40 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously weekly	☐ #2 (40 mg / 0.8 mL) ☐ #4 (40 mg / 0.8 mL)	☐ Pen ☐ PFS	Refills:____
☐ **Humira Citrate Free** 40mg / 0.4 mL (adalimumab)	Initial (if applicable) ☐ Inject 160 mg subcutaneously on day 1 and 80 mg on day 15	☐ #3 (80 mg / 0.8 mL) ☐ #6 (40 mg / 0.4 mL)	☐ Pen Starter Kit ☐ PFS	No Refills
	Maintenance ☐ Inject 40 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously weekly	☐ #2 (40 mg / 0.4 mL) ☐ #4 (40 mg / 0.4 mL)	☐ Pen ☐ PFS	Refills:____
☐ **Simponi** (golimumab)	Initial (if applicable) ☐ Inject 200 mg subcutaneously at week 0 and 100mg at week 2	☐ #3 (100 mg / 1 mL)	☐ Auto Injector ☐ PFS	No Refills
	Maintenance ☐ Inject 100 mg subcutaneously weekly	☐ #4 (100 mg / 1 mL)	☐ Auto Injector ☐ PFS	Refills:____
☐ **Stelara** (ustekinumab)	Initial (if applicable) ☐ Infuse 260 mg intravenously over no less than one hour (≤55kg) ☐ Infuse 390 mg intravenously over no less than one hour (55-85kg) ☐ Infuse 520 mg intravenously over no less than one hour (≥85kg)	☐ #2 (130 mg / 26 mL) ☐ #3 (130 mg / 26 mL) ☐ #4 (130 mg / 26 mL)	Vials	No Refills
	Maintenance (Starting 8 weeks after initial infusion, if applicable) ☐ Inject 90 mg subcutaneously every 8 weeks	☐ #1 (90 mg / 1 mL)	PFS	Refills:____
☐ **Xeljanz** (tofacitinib)	Initial (if applicable) ☐ Take 10 mg by mouth twice daily for 8 weeks	☐ #60 (10 mg tablet)	Tablet	Refills:____
	Maintenance ☐ Take 5 mg by mouth twice daily ☐ Take 10 mg by mouth twice daily	☐ #60 (5 mg tablet) ☐ #60 (10 mg tablet)	Tablet	Refills:____
☐ Other:_____	☐ _____	☐ _____	☐ _____	Refills:____

Prescriber Signature (No Stamps Permitted)

By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent, if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies. To prohibit generic substitution write "brand necessary" or "brand medically necessary" on the face of the prescription in your own handwriting.

Prescriber's Signature : _____ Date: _____