CROHNS & UC (A-K) REFERRAL FORM

BARNERT PHARMACY
"FAST, FRIENDLY, DEPENDABLE SERVICE"

680 Broadway Suite 108
Paterson, NJ 07514

• (P) 973.925.7200 • BarnertPharmacy.com • (F) 973.925.7202

Patient Information

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB_____ Height _____Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address_____ Apt#_____City_____State_____Zip_____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address
Allergies_____
Current Medications including OTC's (*please fax a complete list*)_____

Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____

Primary Insurance _____
ID# _____ Group#_____
Secondary Insurance _____
ID# _____ Group#_____

Ordering Prescriber

Office Contact _____
Street Address _____Suite #_____
City _____State_____Zip_____
Tel _____Fax _____
Email _____
License#_____
NPI# _____

ICD-10 Code **Crohn's Disease** ☐ **K50.00** ☐ **K51.50** ☐ **K50.10** ☐ **K51.80** ☐ **K50.80**
Ulcerative Colitis ☐ **K51.90** ☐**K50.90**

☐ **Yes** ☐ **No** Active TB ruled out? Date:_____ ☐ **Yes** ☐ **No** TB/PPD Test given? Date:_____
☐ **Yes** ☐ **No** Chest X-Ray? Results _____ ☐ **Yes** ☐ **No** Hep B is ruled out / treated?

Previous Meds	**Strength**	**Duration of Treatment**	**Not Tolerated**	**Contraindications**
Methotrexate				
Pentasa				
Entocort				
Humira				
Cimzia				
Enbrel				

Prescription

☐ **PRIOR | CURRENT TREATMENTS**
☐ Azathioprine ☐ Corticosteroids ☐ 5-ASA ☐ 6-MP ☐ NSAIDS ☐ Methotrexate ☐ Sulfasalazine
☐ Other_____ Dose | Duration_____

☐ **CIMZIA 200mg** ☐ **PFS** ☐ **SD Vial**
SIG: ☐ **Starting dose:** 400 mg subcutaneously initially and at weeks 2 & 4 QTY: 6 Refill: _____
☐ **Maintenance dose:** 400 mg subcutaneously every 4 weeks QTY: _____ Refill: _____

☐ **ENTYVIO 300 mg single-use 20 mL vial** Infusion supplies needed? ☐ YES ☐ NO
☐ **Starting dose:** 300 mg infused intravenously over approximately 30 minutes on week 0, week 2 & week 6 then,
☐ **Maintenance dose:** 300 mg infused every 8 weeks QTY: _____ Refill: _____

☐ **HUMIRA STARTER KIT 80 mg/0.8mL** ☐ **PFS** ☐ **Pens**
SIG: ☐ **Starting dose:** Day 1: Inject 160 mg subcutaneously; Day 15: Inject 80 mg subcutaneously QTY: 3 Refill: 0
☐ **Starting dose:** Day 1: Inject 80 mg subcutaneously; Day 2 : Inject 80 mg subcutaneously;
Day 15: Inject 80 mg subcutaneously QTY: 3 Refill: 0

☐ **HUMIRA 40 mg/0.4mL** ☐ **PFS** ☐ **Pens** ☐ **HUMIRA CITRATE-FREE 40 mg/0.4mL** ☐ **PFS** ☐ **Pens**
SIG: ☐ **Maintenance dose:** Day 29: Inject 40 mg/0.8 ml every other week
☐ Other_____ QTY: _____ Refill: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

By signing this form I authorize Barnert Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

_____ **Prescriber's signature** (no stamps) if brand required check this ☐ DAW____ **Date**_____

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Patient Information

Patient Name _____ Today's Date_____ ☐ *NEW Patient* ☐ *CURRENT Patient*
DOB_____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address_____ Apt#_____ City_____ State_____ Zip_____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address
Allergies_____
Current Medications including OTC's (*please fax a complete list*)_____

Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____

Primary Insurance _____
ID# _____ Group#_____
Secondary Insurance _____
ID# _____ Group#_____

Ordering Prescriber

Office Contact _____
Street Address _____ Suite #_____
City _____ State_____ Zip_____
Tel _____ Fax _____
Email _____
License#_____
NPI# _____

ICD-10 Code **Crohn's Disease** ☐ **K50.00** ☐ **K51.50** ☐ **K50.10** ☐ **K51.80** ☐ **K50.80**
Ulcerative Colitis ☐ **K51.90** ☐ **K50.90**

☐ **Yes** ☐ **No** Active TB ruled out? Date:_____ ☐ **Yes** ☐ **No** TB/PPD Test given? Date:_____
☐ **Yes** ☐ **No** Chest X-Ray? Results _____ ☐ **Yes** ☐ **No** Hep B is ruled out / treated?

Previous Meds	Strength	Duration of Treatment	Not Tolerated	Contraindications
Methotrexate				
Pentasa				
Entocort				
Humira				
Cimzia				
Enbrel				

Prescription

☐ **PRIOR | CURRENT TREATMENTS** ☐ Azathioprin ☐ Corticosteroids ☐ 5-ASA ☐ 6-MP ☐ NSAIDS
☐ Methotrexate ☐ Sulfasalazine ☐ Other_____ Dose | Duration_____

☐ **REMICADE 100 mg vial** ☐ **MD Office Infusion** Infusion supplies needed? ☐ YES ☐ NO
SIG: ☐ **Starting dose:** 5 mg/kg ____mg on week 0, week 2 & week 6 then,
☐ **Maintenance dose:** 5 mg/kg _____ mg every 8 weeks for ____ infusions
☐ Other_____ QTY: _____ Refill: _____

Ulcerative Colitis only ☐ **SIMPONI** ☐ **SmartJect™** ☐ **PFS**
☐ **Starting dose:** 200 mg subcutaneously at week 0, then 100 mg subcutaneously at week 2 QTY: 3 (100 mg/mL)
☐ **Maintenance dose:** 100 mg subcutaneously every 4 weeks QTY: 1 (100 mg/mL)
☐ Other_____ QTY: _____ Refill: _____

Crohn's Disease only ☐ **STELARA** ☐ **130 mg/26 mL SD Vial** ☐ **45mg PFS** ☐ **90mg PFS** ☐ **45mg SD Vial**
SIG: ☐ **Starting dose:** Infuse ____mg IV initially, then maintenance
☐ **Maintenance dose:** Inject 90 mg subcutaneously 8 weeks after the initial IV dose, then every 8 weeks
QTY: _____ Refill: _____

Weight of Pt (Kg)	Recmd Dosage	Vials
≤ 55 kg or less	260 mg	2
55 kg to 85 kg	390 mg	3
≥ 85 kg	520 mg	4

Ulcerative Colitis only ☐ **XELJANZ** ☐ **5 mg tablet** ☐ **10 mg tablet**
SIG: ☐ **Starting dose:** _____ mg orally twice a day with or without food for _____ weeks QTY: _____ Refill: _____
☐ **Maintenance dose:** _____ mg orally twice a day QTY: _____ Refill: _____

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