CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

V-Care Pharmacy
Specialty + Medical & Surgical Supplies
151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | 844.7.MYVCARE | Fx 508.202.9343

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy Date Needed

Diagnosis: Crohn's Disease ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Ulcerative Colitis ☐ K51.20 ☐ K51.80 ☐ K51.90

TB/PPD Test given? ☐ Yes ☐ No Chest X-Ray ☐ Yes ☐ No Results

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRIOR | CURRENT TREATMENTS

☐ Azathioprine ☐ Corticosteroids
☐ 5-ASA ☐ 6-MP ☐ NSAIDS
☐ Methotrexate ☐ Sulfasalazine
☐ Other
Dose | Duration

SIMPONI ® (golimumab) ☐ SmartJect™ ☐ Prefilled Syringe

☐ **STARTER** 200mg SC at week 0, then 100mg SC at week 2 **QTY:** 3 (100 mg/mL)
MAINTENANCE
☐ 100mg SC every 4 weeks **QTY:** 1 (100 mg/mL)
☐ 50mg SC every 4 weeks **QTY:** 1 (50 mg/0.5mL)
☐ Other Refill X

HUMIRA

☐ **STARTER** Day 1: Inject 160mg (4 pens) SQ.
Day 15: Inject 80mg (2 pens) SQ.
Day 29: maintenance
☐ **MAINTENANCE** Inject (1 Pen) 40mg/0.8ml every other week
☐ Other
QUANTITY 4 week supply Refill X

CIMZIA

☐ **STARTER** 400mg SQ initially and at week 2 & 4
☐ **MAINTENANCE** 400 mg SQ every 4 weeks
QUANTITY 4 week supply Refill X

XIFAXAN 550mg tablet

☐ **SIG**
QTY Refills

REMICADE 100 mg vial

☐ MD Office Infusion
Infusion supplies needed ☐ YES ☐ NO
☐ **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 every 8 weeks
☐ Other
QTY _____ Refills _____

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

Prescriber's Signature (signature required. NO STAMPS) **Date**

Please fax completed referral form to **V-Care Pharmacy & Surgical Supplies** at **508.202.9343** Visit us at **WWW.MYVCAREPHARMACY.COM** for online fillable forms.