V-CARE PHARMACY

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

151 Cochituate Rd | Framingham, MA 01701
PHONE: 508-202-9993 | FAX: 508-202-9343 | 844-7-MYVCARE

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ D.O.B _____ Weight _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Daytime Telephone _____ Evening Telephone _____ 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 ☐ K50.90 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

PRIOR/CURRENT TREATMENTS

☐ Azathioprine ☐ Corticosteroids
☐ 5-ASA ☐ 6-MP
☐ Methotrexate ☐ Sulfasalazine
☐ Other _____
Dose/Duration _____

SIMPONI® (golimumab) ☐ SmartJect™ ☐ Prefilled Syringe

☐ **STARTER** 200 mg SC at week 0, then 100 mg SC at week 2 **QTY:** 3 (100 mg/mL)

MAINTENANCE

☐ 100 mg SC every 4 weeks **QTY:** 1 (100 mg/mL)
☐ 50 mg SC every 4 weeks **QTY:** (50 mg/0.5mL)
☐ Other _____ Refill X _____

HUMIRA

☐ **STARTER** Day 1: Inject 160 mg (4 pens) SQ.
Day 15: Inject 80 mg (2 pens) SQ.
Day 29: Maintenence
☐ **MAINTENANCE** Inject (1 Pen) 40 mg/0.8mL every other week
☐ Other _____
QTY: 4 Week Supply Refill X _____

CIMZIA

☐ **STARTER** 400 mg SQ initially and at week 2 & 4
☐ **MAINTENANCE** 400 mg SQ every 4 weeks
QTY: 4 Week Supply Refill X _____

XIFAXAN 550 mg tablets

☐ **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: _____

This is **not** a valid prescription and is intended for reference only. For providers: **Please send a valid prescription electronically or via fax.**

Prescriber's Signature (no stamps) _____ **Date** _____