

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

HOMETECH ADVANCED THERAPIES
Fax Referral To: 855-884-9283



Date: _____

Phone: 855-494-3121

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: _____

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: _____

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: _____

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: _____

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: _____

Other/Notes: _____

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

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