Crohn's and Ulcerative Colitis Referral Form

Date: _____

Y Medical Associates
Fax : 855-838-0623
Phone: 800-447-7558

YMedical ASSOCIATES

Patient Information

Please complete the following or send patient demographic sheet

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
DOB: _____ Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA: _____ NPI #: _____
Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Medical Information (Section must be completed to process prescription) (Attach separate sheet if needed)

Prior Authorization Insurance Number: _____

Diagnosis - Please include diagnosis name with ICD-10 code

☐ K50.00 Crohn's disease of small intestines without complications
☐ K50.8 Crohn's disease of both intestines without complications
☐ K50.10 Crohn's disease of large intestines without complications
☐ K50.00 Crohn's disease, unspecified, without complications
☐ K20.0 Eosinophilic Esophagitis
☐ Other diagnosis: ICD-10 code _____
Description _____ Date of Description _____
Has a TB test been performed? ☐ Yes ☐ No
Does the Patient have an active infection? ☐ Yes ☐ No
Start Date _____ Review Date _____

Therapy Details: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in
Allergies _____
Lab Data _____
Prior Therapies _____
Concomitant Medications _____
Additional Comments _____
Injection Training Required? ☐ Yes ☐ No

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
☐ Cimzia	☐ 200mg/mL Vial Kit ☐ 200 mg/mL Starter Ki ☐ 200mg/mL prefilled Syringe	☐ **Loading Dose:** Inject 400mg SUBQ at Weeks 0, 2, and 4 ☐ **Maintenance Dose:** Inject 200mg SUBQ every 2 weeks		
☐ Dupixent	☐ PFS with needle shield 300 mg/2 mL ☐ Prefilled Pen 300 mg/2 mL	☐ Inject 300 mg SUBQ every week		
☐ Entyvio	☐ 300mg vial	**Loading Dose:** Inject 300mg IV over 30 minutes at Weeks 0, 2, and 6. **Maintenance Dose:** Infuse 300mg IV over 30 minutes every 8 weeks		
☐ Humira ☐ Adalimumab *(biosimilar)*	**Starter Kits:** ☐ 80mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) **Maintenance:** ☐ 40mg/0.4mL Pre-Filled Pen (Citrate Free) ☐ 40mg/0.4mL Pre-Filled Syringe (Citrate Free) ☐ Other: _____	**Adult:** ☐ **Loading Dose:** Inject 160mg SUBQ on Day 1, then 80mg on Day 15 (two weeks later) ☐ **Maintenance Dose:** Inject 40mg SUBQ every other week (starting Day 29) **Pediatric (>6 years and adolescents) 17kg to < 40kg** ☐ **Loading Dose:** Inject 80mg SUBQ on Day 1, 40mg on Day 15 (two weeks later) ☐ **Maintenance Dose:** Inject20mg SUBQ every other week (starting Day 29) **Pediatric (>6 years and adolescents) > 40kg** ☐ **Loading Dose:** Inject 160mg SUBQ on Day 1, 80mg on Day 15 (two weeks later) ☐ **Maintenance Dose:** Inject 40mg SUBQ every other week (starting Day 29)		

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

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intend recipient, please notify us immediately by calling or faxing back to the originator.

Crohn's and Ulcerative Colitis Referral Form

Date: _____

Y Medical Associates
Fax : 855-838-0623
Phone: 800-447-7558

YMedical ASSOCIATES

Patient Information

Please complete the following or send patient demographic sheet

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
DOB: _____ Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: _____
Address: _____ City,
State, Zip: _____
Phone: _____
Fax: _____
DEA: _____ NPI #: _____
Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Medical Information (Section must be completed to process prescription) (Attach separate sheet if needed)

Prior Authorization Insurance Number: _____

Diagnosis - Please include diagnosis name with ICD-10 code

☐ K50.00 Crohn's disease of small intestines without complications
☐ K50.8 Crohn's disease of both intestines without complications
☐ K50.10 Crohn's disease of large intestines without complications
☐ K50.00 Crohn's disease, unspecified, without complications
☐ Other diagnosis: ICD-10 code _____
Description _____ Date of Description _____
Has a TB test been performed? ☐ Yes ☐ No
Does the Patient have an active infection? ☐ Yes ☐ No
Start Date _____ Review Date _____

Therapy Details: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in
Allergies _____ Lab
Data _____ Prior
Therapies _____
Concomitant Medications _____
Additional Comments _____
Injection Training Required? ☐ Yes ☐ No

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ 100mg Vial	☐ **LoadingDose:** Infuse 5mg/kg at Weeks 0, 2, and 6 ☐ **Maintenance Dose:** Infuse 5mg/kg every 8 weeks		
☐ Rinvoq	☐ **Induction Therapy** – 45 mg tablet ☐ **Maintenance Therapy** – 15 mg or 30 mg tablets	☐ **Induction Therapy:** 45 mg PO daily x 8 weeks. **Maintenance Therapy:** ☐ 15 mg PO daily ☐ 30 mg PO daily		
☐ Simponi	100mg/mL Smart Ject Auto Injector 100mg/mL Prefilled Syringe	☐ **Loading Dose:** Inject 200 mg SUBQ at Week0 then 100mg at Week 2 ☐ **Maintenance Dose:** Inject 100mg SUBQ every 4 weeks		
☐ Stelara	☐ 130mg/26mL solution single dose vial ☐ 90mg/mL Prefilled Syringe Date of Initial Infusion: _____	**Loading Dose:** Infuse: ☐ 250mg ☐ 390mg ☐ 520mg as initial IV dose as directed by prescriber **Maintenance Dose:** Inject 90mg SUBQ every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
☐ Skyrizi	☐ **Initiation Therapy** – 600 mg/10 mL single use vial. ☐ **Ongoing Therapy** – 360 mg/2.4 mL prefilled cartridge with On-Body Injector	☐ **Initiation Therapy** – ☐ Inject 600 mg IV over at least 1 hour at Weeks 0, 4, 8. 1 vial/week. ☐ **Ongoing Therapy** – Week 12 – Inject 360 mg SUBQ and every 8 weeks thereafter. 1 device with prefilled cartridge.		
☐ Tremfya	**Subcutaneous Injection:** ☐ 100 mg/mL in a single-dose One-Press patient-controlled injector ☐ 200 mg/2 mL in a single-dose prefilled pen (Tremfya Pen) ☐ 100 mg/mL in a single-dose prefilled syringe ☐ 200 mg/2 mL in a single-dose prefilled syringe **Intravenous Infusion:** ☐ 200 mg/20 mL (10 mg/mL) solution in a single-dose vial	**Induction:** ☐ 200 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, Week 8 **Maintenance**: ☐ 100 mg administered by subcutaneous injection at Week 16, and every 8 Week thereafter, or 200 mg administered by subcutaneous injection at Week 12, and every 4 Weeks thereafter. Use the lowest effective recommended dosage to maintain therapeutic response.		
☐ Xeljanz	☐ 5mg tablet ☐ 10mg tablet ☐ 11mg XR tablet ☐ 22mg XR tablet	☐ **Loading Dose:** ☐ 10mg twice daily for 8 weeks ☐ XR: 22mg once for 8 weeks ☐ **Maintenance Dose:** ☐ 5mg twice daily ☐ XR: 11mg once daily ☐ 10mg twice daily ☐ XR: 22mg once daily		

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

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intend recipient, please notify us immediately by calling or faxing back to the originator.