

**Crohn's and Ulcerative Colitis Referral Form**

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



Date: \_\_\_\_\_

**Patient Information**

Please complete the following or send patient demographic sheet

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Alternate 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)**

<p><b>Diagnosis:</b></p> <p><input type="checkbox"/> K50.0 - Crohn's disease of small intestine</p> <p><input type="checkbox"/> K50.1 - Crohn's disease of large intestine</p> <p><input type="checkbox"/> K50.8 - Crohn's disease of both small and large intestine</p> <p><input type="checkbox"/> K50.9 - Crohn's disease, unspecified</p> <p><input type="checkbox"/> K51 - Ulcerative colitis</p> <p><input type="checkbox"/> K51.9 - Ulcerative colitis, unspecified</p> <p><input type="checkbox"/> Other diagnosis: ICD-10 code _____</p> <p>Description _____ Date of Description _____</p> <p>Is patient up to date on all required labs/vaccinations as required by therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Therapy Details:</b> <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart</p> <p>Weight _____ kg/lbs Height _____ cm/in</p> <p>Allergies _____</p> <p>Lab Data _____</p> <p>Prior Therapies _____</p> <p>Concomitant Medications _____</p> <p>Additional Comments _____</p> <p>Injection Training Required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Home <input type="checkbox"/> Office</p>
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**Prescription Information**

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300 mg vial	<input type="checkbox"/> <b>Loading Dose IV:</b> 300mg over 30 minutes at Week 0, 2, and 6. <input type="checkbox"/> <b>Maintenance Dose IV:</b> 300mg over 30 minutes every 8 weeks		
<input type="checkbox"/> Omvoh	<b>CD:</b> <input type="checkbox"/> 300mg/15mL vial (IV) <input type="checkbox"/> 200mg/2mL + 100mg/mL PFP (SUBQ) <input type="checkbox"/> 200mg/2mL + 100mg/mL PFS (SUBQ) <b>UC:</b> <input type="checkbox"/> 300mg/15mL vial (IV) <input type="checkbox"/> 100mg/mL + 100mg/mL PFP (SUBQ) <input type="checkbox"/> 100mg/mL + 100mg/mL PFS (SUBQ)	<b>CD:</b> <input type="checkbox"/> <b>Loading Dose -</b> 900mg IV over at least 90 minutes at Weeks 0,4, & 8 <input type="checkbox"/> <b>Maintenance Dose:</b> 300mg SUBQ (consecutive injections of 100mg + 200mg) <b>UC:</b> <input type="checkbox"/> <b>Loading Dose:</b> 300mg IV over at least 30 minutes at Weeks 0, 4, & 8 <input type="checkbox"/> <b>Maintenance Dose:</b> 200mg SUBQ (consecutive injections of 100mg + 100mg)		
<input type="checkbox"/> Remicade <input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis <input type="checkbox"/> Infliximab	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> <b>Loading Dose IV:</b> 5mg/kg at Weeks 0, 2, and 6 <input type="checkbox"/> <b>Maintenance Dose IV:</b> 5mg/kg every 8 weeks (Starting Week 14)		
<input type="checkbox"/> Stelara <input type="checkbox"/> Approve switch to preferred biosimilar	<b>Loading Dose IV based on weight:</b> <input type="checkbox"/> 260mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg  <b>Maintenance Dose SUBQ:</b> <input type="checkbox"/> 90mg	<b>Loading Dose IV based on weight:</b> <input type="checkbox"/> 260mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg  <b>Maintenance Dose SUBQ:</b> <input type="checkbox"/> 90mg q 8 weeks (beginning 8 weeks after loading dose)		

Prescriber Signature: \_\_\_\_\_ DAW (Dispense as Written)  Y  N Date: \_\_\_\_\_

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DEA: \_\_\_\_\_ NPI #: \_\_\_\_\_

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Prescription Card: \_\_\_\_\_ ID#: \_\_\_\_\_ BIN#: \_\_\_\_\_ PCN#: \_\_\_\_\_ Group: \_\_\_\_\_

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

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**Prescription Information**

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Skyrizi	<b>IV:</b> <input type="checkbox"/> 600 mg/10 mL vial <b>SUBQ:</b> <input type="checkbox"/> 180 mg/1.2 mL PFS <input type="checkbox"/> 180 mg/1.2 mL OBI <input type="checkbox"/> 360 mg/2.4 mL OBI	<b>Loading Dose (CD):</b> <input type="checkbox"/> 600mg IV over at least 1 hour at Weeks 0, 4, & 8 <b>Loading Dose (UC):</b> <input type="checkbox"/> 1200mg IV over least 2 hours at Weeks 0, 4, & 8 <b>Maintenance Dose</b> <input type="checkbox"/> 180 mg SUBQ at Week 12, then q 8 weeks thereafter <input type="checkbox"/> 360 mg SUBQ at Week 12, then q 8 weeks thereafter		
<input type="checkbox"/> Tremfya	<b>IV:</b> <input type="checkbox"/> 200 mg/20 mL vial <b>SUBQ:</b> <input type="checkbox"/> 100 mg/mL PFS <input type="checkbox"/> 100 mg/mL PFP <input type="checkbox"/> 100 mg/mL OBI <input type="checkbox"/> 200 mg/2mL PFS <input type="checkbox"/> 200 mg/2mL PFP	<b>Loading Dose:</b> <input type="checkbox"/> 200mg IV over at least 1 hour on Weeks 0, 4, & 8 <input type="checkbox"/> 400mg SUBQ on Weeks 0, 4, & 8 <b>Maintenance Dose:</b> <input type="checkbox"/> 100mg SUBQ at Week 16, and every 8 weeks thereafter <input type="checkbox"/> 200mg SUBQ at Week 12, then every 4 weeks thereafter		
<input type="checkbox"/> Tysabri <input type="checkbox"/> Tyruko <input type="checkbox"/> Approve switch to preferred biosimilar	<input type="checkbox"/> 300mg IV over 1 hour every 4 weeks	<input type="checkbox"/> IV: 300mg over 1 hour q 4 weeks		

Prescriber Signature: \_\_\_\_\_ DAW (Dispense as Written)  Y  N Date: \_\_\_\_\_

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