DR. IKES PHARMACY
ADVANCED SPECIALTY PHARMACY

CROHN'S DISEASE/HEPATITIS B
REFERRAL FORM

Fax: **888.804.7717**

Ship To: ❑ Patient ❑ Physician/Clinic Date Shipment Needed: _____ **Rx**: ❑ New ❑ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alt. Phone: _____
Patient SS#: _____
DOB: _____
Allergies: _____
Gender: ❑ Male ❑ Female

Diagnosis: _____ ***ICD10 Code:*** _____
❑ K50.00 Crohn's Disease ❑ K51.80 Ulcerative Colitis
Patient's Weight: _____ Height: _____

Primary Insurance: _____
ID#: _____ Phone: _____
Secondary Insurance: _____
ID#: _____ Phone: _____
Has patient received a PPD (tuberculosis) Skin Test?
❑ Yes ❑ No Results: _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

PRESCRIPTION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **Humira®**	❑ Humira Induction Dose ❑ Pens ❑ Prefilled Syringes (PFS)	**Induction Dose** ❑ 160 mg Sub-Q Day 1, 80 mg Day 15, 40 mg Day 29 & every other week thereafter	❑ 1 Kit = 6 x 40 mg Pens ❑ 3 Cartons = 6 x 40 mg PFS	0
	❑ 40 mg Pens ❑ 40 mg Prefilled Syringes (PFS)	**Maintenance Dose** ❑ 40 mg Sub-Q every other week	❑ 1 Carton = 2 x 40 mg Pens ❑ 1 Carton = 2 x 40 mg PFS	
		❑ 40 mg Sub-Q once weekly	❑ 2 Cartons = 4 x 40 mg Pens ❑ 2 Cartons = 4 x 40 mg PFS	_____
❑ **Cimzia®**	❑ Cimzia Starter Kit (Prefilled Syringes) ❑ 200 mg Lyophilized Vials (LYO)	**Induction Dose** ❑ 400 mg Sub-Q at weeks 0, 2 and 4	❑ 1 Kit = 6 x 200 mg/mL PFS ❑ 3 Cartons = 6 x 200 mg Vials (LYO)	0
	❑ 200 mg/mL Prefilled Syringes ❑ 200 mg Lyophilized Vials (LYO)	**Maintenance Dose** ❑ 400 mg Sub-Q every 4 weeks ❑ 200 mg Sub-Q every 2 weeks	❑ 1 Carton = 2 x 200 mg/mL PFS ❑ 1 Carton = 2 x 200 mg Vials (LYO)	_____
❑ **Simponi®**	❑ 100 mg/1 mL SmartJect® Autoinjector	**Induction Dose** ❑ 200 mg Sub-Q at Weeks 0, 100 mg at Week 2 and every 4 weeks thereafter	❑ 3x100 mg SmartJect® Autoinjector ❑ 3 x 100 PFS	0
	❑ 100 mg/1 mL Prefilled Syringe	**Maintenance Dose** ❑ 100 mg Sub-Q every 4 weeks	❑ 1x100 mg SmartJect® Autoinjector ❑ 1 x 100 PFS	_____
❑ **Remicade**	❑ 100 mg Vial # of Vials _____			
❑ **Entyvio®**	❑ 300 mg Lyophilized Vials	**Initial Dose:** ❑ 300 mg Intravenously at weeks 0, 2, 6 **Maintenance Dose:** ❑ 300 mg IV every 8 weeks	_____ vials for 6 week supply _____ vials for 8 week supply	_____

❑ **Nursing** _____

HEPATITIS B

❑ B18.1 Hepatitis B ❑ Baraclude 1mg ❑ Tyzeka 600mg ❑ Xifaxan 200 mg
❑ Baraclude 0.5mg ❑ Epivir HBV 100mg ❑ Viread ❑ Xifaxan 550 mg
❑ Hepsera 10mg

Directions: _____ Quantity: _____ Refills: _____

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____
Address: _____ License#: _____
City, State, Zip: _____ DEA#: _____
Phone: _____ Fax: _____ Contact Name: _____
Physician's Signature: _____ Date: _____

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.