CROHN'S DISEASE/ULCERATIVE COLITIS PRESCRIPTION REFERRAL FORM

REALO X SPECIALTY CARE PHARMACY

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: _____ ❑Male ❑Female SS#: _____ DOB: _____
Address: _____ City, State, Zip: _____
Primary Phone: _____ ❑Home ❑Cell ❑Work Alternate Phone: _____ ❑Home ❑Cell ❑Work
Email: _____ Height: _____ Weight: _____
Allergies: _____ Comorbidities: _____

PRESCRIBER INFORMATION

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

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: _____
Date Shipment Needed By: _____ ❑Alternate Location: _____
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis/ICD-10: K50. _____
K51. _____
Date of Diagnosis: _____
Patient has negative TB test results? ❑yes ❑no Date of Test: _____
Prior History: ❑5-ASA ❑Immunosuppressants (6-MP or other) ❑Corticosteroids ❑Methotrexate ❑Surgery ❑Other: _____

Prior Biologic Use: Date of Last Dose:
❑Cimzia® _____
❑Humira® _____
❑Remicade® _____
❑Simponi® _____
❑Inflectra _____
❑Entyvio _____
❑Stelara® _____
❑Other (please specify) _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILL	DIRECTIONS
❑Cimzia® ❑injection training	❑Cimzia® Starter Kit (PFS) ❑200 mg lyophilized vials ❑200 mg/mL PFS ❑200 mg lyophilized vials	❑1 kit = 6 x 200 mg/mL PFS ❑3 cartons = 6 x 200 mg lyophilized ❑1 carton = 2 x 200 mg/mL PFS ❑1 carton = 2x 200 mg vials	0	Induction Dose: ❑400 mg Sub-Q at weeks 0, 2 and 4 Maintenance Dose: ❑400 mg Sub-Q every 4 weeks
❑Humira® ❑Citrate Free ❑injection training	❑40 mg pens ❑20 mg PFS ❑40 mg PFS ❑40 mg pens ❑40 mg PFS ❑20 mg PFS	❑1 kit ❑1 kit Pediatric Starter Kit ❑1 carton = 2 x 40 mg pens ❑1 carton = 2 x 40 mg PFS ❑1 carton = 2 x 20 mg PFS		Induction Dose: ❑160 mg Sub-Q day 1, 80 mg day 15, 40 mg day 29 and every other week thereafter (adults and children ≥ 88 lb [40 kg]) ❑80 mg Sub-Q day 1, 40 mg day 15, 20 mg day 29 and every other week thereafter (children 37 to 88 lbs [17-40kg]) Maintenance Dose: ❑40 mg Sub-Q every other week (adults and children ≥ 88 lbs [40kg]) ❑20 mg Sub-Q every other week (children 37 to 88 lbs [17-40 kg])
❑Simponi® ❑injection training	❑100 mg/mL SmartJect® Autoinjector ❑100 mg/mL PFS	❑3 x 100 mg SmartJect® Autoinjector ❑3 x 100 mg PFS ❑1 x 100 mg SmartJect® ❑1 x 100 mg PFS		Induction Dose: ❑200 mg Sub-Q at weeks 0, 100 mg Sub-Q at week 2 and every 4 weeks thereafter Maintenance Dose: ❑100 mg Sub-Q every 4 weeks
❑Stelara® ❑injection training	❑90 mg	❑1 x 90 mg PFS		Induction Dose: ❑ IV induction completed at office Maintenance Dose: ❑90mg Sub-Q every 8 weeks beginning 8 weeks after IV induction
❑Xeljanz®	❑5 mg tablet ❑10 mg tablet	❑60 tablets		Induction Dose: ❑10mg tablet twice daily for 8 weeks Maintenance Dose: ❑5mg twice daily ❑10mg twice daily

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature | Date | Substitution Permissable - Signature | Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.