CROHN'S DISEASE/ULCERATIVE COLITIS (INFUSION) 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
❑Entyvio®	❑300mg/20ml SDV	❑ _____ mg		❑300 mg at 0, 2, and 6 weeks then every 8 weeks thereafter
❑Remicade®	❑5mg/kg	❑ _____ mg		❑IV: 5 mg/kg at 0, 2, and 6 weeks, followed by 5mg/kg every 8 weeks thereafter.
❑Stelara®	Induction, IV: ❑≤55 kg: 260 mg ❑>55 kg to 85 kg: 390 mg ❑>85 kg: 520 mg ❑Maintenance, SubQ: 90 mg	❑ _____ mg		Induction, IV: ❑≤55 kg: 260 mg as single dose ❑>55 kg to 85 kg: 390 mg as single dose ❑>85 kg: 520 mg as single dose Maintenance: ❑SubQ: 90 mg every 8 weeks; begin maintenance dosing 8 weeks after the IV induction dose

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.