MEMORIAL HERMANN Specialty Pharmacy

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

Adult Non-Infusion Drugs

Prescriber, please sign and fax completed form to 713.704.3841
For questions, please call 281.698.6100

SHIP TO:
- ☐ Patient
- ☐ Office (1st dose)
- ☐ Office (All doses)

Patient Information

Please include copy of prescription and medical insurance card, front and back

Patient Name: _____ Date of Birth: _____
Street Address: _____ Phone: _____
City, State, Zip: _____ Allergies: _____

Prescriber Information

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

Patient Medical Information

**Please include copies of any pertinent clinical notes and lab work **

Diagnosis (ICD-10):
- ☐ K50.0 (Chrohn's Disease of the Small Intestine)
- ☐ K50.1 (Chrohn's Disease of the Large Intestine)
- ☐ K50.8 (Chrohn's Disease of the Both Intestine)
- ☐ K50.9 (Chrohn's Disease, unspecified)
- ☐ K51.0 (Ulcerative Pancolitis)
- ☐ K51.2 (Ulcerative Procolitis)
- ☐ K51.3 (Ulcerative Rectosigmoiditis)
- ☐ K51.5 (Left Sided Colitis)
- ☐ K51.8 (Other Ulcerative Colitis)
- ☐ K51.9 (Ulcerative Colitis, Unspecified)
- ☐ Other: _____

Diagnosis Date: _____ Date of negative TB Test: _____ Date of negative chest X-ray (if TB positive): _____

Previous and/or Current Medications Used to Treat this Diagnosis:

Medication Name(s)	Current Use	Start Date	End Date	Discontinue Reason (if stopped)
				Failed Other Explanation: _____
				Failed Other Explanation: _____
				Failed Other Explanation: _____

Drug Name	Dosing	Quantity	Form	Refills
☐ Cimzia (certolizumab)	Initial (if applicable) ☐ Inject 400 mg subcutaneously at weeks 0, 2, and 4	☐ #6 (200 mg / 1 mL)	☐ PFS ☐ Vial	No Refills
	Maintenance ☐ Inject 400 mg subcutaneously every 4 weeks	☐ #2 (200 mg / 1 mL)	☐ PFS ☐ Vial	Refills: _____
☐ Entyvio (Vedolizumab)	Initial Induction: ☐ Infuse 300 mg over 30 minutes at 0, 2, and 6 weeks and then every 8 weeks thereafter.	— _____	☐ 300 mg vial.	Refills: _____
	Maintenance ☐ Inject 108 mg subcutaneously once every 2 weeks beginning after at least 2 IV infusions; administer in place of next scheduled IV dose and then every 2 weeks thereafter.	☐ #2	☐ 108 mg PFS.	Refills: _____
☐ Humira (adalimumab)	Initial (if applicable) ☐ Inject 160 mg subcutaneously on Day 1, then 80 mg on day 15 ☐ Inject 80 mg subcutaneously on Day 1, 80 mg on Day 2, 80 mg on day 15	☐ #1 (80 mg/0.8mL Crohn's Starter Kit - citrate-free) ☐ #1 (40 mg/0.8mL Crohn's Starter Kit)	☐ Pen Starter Kit	No Refills
	Maintenance ☐ Inject 40 mg subcutaneously every other week (starting day 29)	☐ #2 (40 mg/0.4mL) - Citrate Free ☐ #2 (40 mg/0.8mL)	☐ Pen ☐ PFS	Refills: _____
☐ Rinvoq (upadacitinib)	Initial (if applicable) ☐ Take 45 mg by mouth once daily for 8 weeks	☐ #56 tablets (45 mg tablet)	Tablet	No Refills
	Maintenance ☐ Take 15 mg by mouth once daily ☐ Take 30 mg by mouth once daily	☐ #30 (15 mg tablet) ☐ #30 (30 mg tablet)	Tablet	Refills: _____
☐ Simponi (golimumab)	Initial (if applicable) ☐ Inject 200 mg subcutaneously at week 0 and 100mg at week 2	☐ #3 (100 mg / 1 mL)	☐ Auto Injector ☐ PFS	No Refills
	Maintenance ☐ Inject 100 mg subcutaneously every 4 weeks	☐ #4 (100 mg / 1 mL)	☐ Auto Injector ☐ PFS	Refills: _____
☐ Stelara (ustekinumab)	Initial (if applicable) ☐ Infuse 260 mg intravenously over no less than one hour (equal or less than 55kg) ☐ Infuse 390 mg intravenously over no less than one hour (55-85kg) ☐ Infuse 520 mg intravenously over no less than one hour (equal or greater than 85kg)	☐ #2 (130 mg / 26 mL) ☐ #3 (130 mg / 26 mL) ☐ #4 (130 mg / 26 mL)	Vials	No Refills
	Maintenance (Starting 8 weeks after initial infusion, if applicable) ☐ Inject 90 mg subcutaneously every 8 weeks	☐ #1 (90 mg / 1 mL)	PFS	Refills: _____
☐ Xeljanz (tofacitinib)	Initial (if applicable) ☐ Take 10 mg by mouth twice daily for 8 weeks	☐ #60 (10 mg tablet)	Tablet	Refills: _____
	Maintenance ☐ Take 5 mg by mouth twice daily ☐ Take 10 mg by mouth twice daily	☐ #60 (5 mg tablet) ☐ #60 (10 mg tablet)	Tablet	Refills: _____
☐ Skyrizi (risankizumab)	Initial (if applicable) ☐ Infuse 600 mg intravenously over at least one hour at weeks 0, 4, and 8	☐ #3 (600 mg / 10 mL)	Vial	No Refills
	Maintenance ☐ Inject 360 mg subcutaneously at week 12, then every 8 weeks	☐ #1 (360 mg / 2.4 mL)	Prefilled cartridge	Refills: _____
☐ Velsipity (etrasimod)	☐ Take 2 mg orally once daily	☐ #30 (2 mg tablet)	Tablet	Refills: _____
☐ Zeposia (ozanimod)	Initial (if applicable) ☐ Take 0.23 mg by mouth once daily on days 1-4, then 0.46 mg once daily on days 5-7	☐ #1 (7-day starter pack)	Capsule Starter Pack	No Refills
	Alternate Initial (if applicable) ☐ Take 0.23 mg by mouth once daily on days 1-4, then 0.46 mg once daily on days 5-7, then 0.92 mg once daily starting on day 8	☐ #1 (37-day starter kit – 7-day starter pack + 0.92 mg capsules)	Capsule Starter Kit	No Refills
	Maintenance ☐ Take 0.92 mg by mouth once daily	☐ #30 (0.92 mg capsule)	Capsule	Refills: _____

Prescriber Signature (No Stamps Permitted)

By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent, if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies. To prohibit generic substitution write "brand necessary" or "brand medically necessary" on the face of the prescription in your own handwriting.

Prescriber's Signature : _____ **Date:** _____