Crohn's / GI / UC
Prescription Referral Form

Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont
Specialty Pharmacy
www.rosemontspecialtyrx.com

Date Medication Needed: ______________ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up

1: Patient Information

Patient Name: ______________ **Birthdate:** ______________ **Sex:** ○ Male ○ Female **Height:** ________ **Weight:** ________ ○ lbs. ○ kg.

Soc. Sec. #: ______________ **Preferred Phone:** ______________ **Known Allergies:** ______________

Address: ______________ **City:** ______________ **State:** ________ **Zip:** ________

Alternate Caregiver Name: ______________ **Preferred Phone:** ______________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: ______________ **DEA#:** ________ **NPI#:** ________ **Tax ID#:** ________

Address: ______________ **Phone:** ______________ **Fax:** ______________

City, State, Zip: ______________ **Key Contact:** ______________ **Phone:** ______________

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: ______________ **ICD-10:** ______________

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ Cimzia®	☐ Prefilled Syringes (2x200mg) (or) ☐ Lyophilized vials (2 x 200mg)	**Starter Dose:** ☐ Inject 400mg SC at weeks 0, 2, and 4 **Maintenance Dose:** ☐ 400mg SC every 4 weeks	________ ________	0 ________
☐ Humira® ☐ Injection training from My Humira *(patient must sign below)*	☐ 20mg Pen ☐ 20mg Prefilled Syringe ☐ 40mg Pen ☐ 40mg Prefilled Syringe ☐ Starter Pack	**Starter Dose:** ☐ Inject 160mg SC (four 40mg Pens) for first Dose (Day 1). Then Inject 80mg SC (two 40mg Pen) two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29) **Maintenance Dose:** ☐ Inject 40mg SC (one 40mg Pen) every other week ☐ Other ______________	________ ________	0 ________
☐ Xifaxan®	☐ 200mg tabs ☐ 550mg tabs	Take ____ tablets ____ times per day		
☐ Remicade®	☐ 100mg vial			
☐ Simponi®	☐ 100mg SmartJect® ☐ 100mg Prefilled Syringe	**Starter Dose:** ☐ Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 **Maintenance Dose:** ☐ 100mg SC every 4 weeks starting at week 6, after Induction dose	3 1	0 ________
☐ Entyvio®	☐ 300mg vial			
☐ Dificid®	☐ 200mg tabs	☐ Take 1 tablet twice daily with or without food for 10 days	20 Tablets	
☐ Stelara® Starter Dose	☐ 2x 130mg/26ml ☐ 3x 130mg/26ml ☐ 4x 130mg/26ml	</=55kg ☐ Infuse 260mg IV as induction dose over at least 1 hour >55kg to </=85kg ☐ Infuse 390mg IV as induction dose over at least 1 hour >85kg ☐ Infuse 520mg IV as induction dose over at least 1 hour ☐ Low-dose induction: Infuse 130mg IV over at least 1 hour	________ vials	0
☐ Stelara®	☐ 1x 90mg/ml Prefilled Syringe	☐ Inject 90mg SC 8 weeks after initial IV dose and then every 8 weeks thereafter	1x90mg/ ml PFS	
☐				

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: ______________ Date: ______________

Prescriber Signature: Prescriber, please sign and date below

Dispense as written ______________ Date ______________ Substitution Permissable ______________ Date ______________

I authorize Rosemont Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressed and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient do not distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately.

# of Prescriptions: ______________