Crohn's/GI/UC
Prescription Referral Form
Phone: 1.877.592.7988
Fax: 1.800.787.0874
Revised: 09/09/2019

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

ACHC ACCREDITED urac ACCREDITED Specialty Pharmacy Expires 01/01/2020

1. Patient Information

Patient Name:		SSN:	DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD 10:

4. Prescription Information: For IV medications attach a copy of your prescription

Medication	Dose/Strength	Sig/Directions	Quantity	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 **Other** ☐ _____	_____ _____ _____	_____ _____
☐ **Humira®**	☐ 20mg/0.2mL Pen ☐ 20mg/0.2mL Prefilled Syringe ☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL Prefilled Syringe ☐ 80mg/0.8mL Pen ☐ 80mg/0.8mL 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:** ☐ _____	_____ _____ _____	_____ _____
☐ **Humira®** Citrate-Free	☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL Prefilled Syringe ☐ 80mg/0.8mL Pen ☐ 80mg/0.8mL Prefilled Syringe ☐ Starter Pack (3-80mg Pens)	**Starter Dose:** ☐ Inject 160mg SC (two 80mg/0.8mL Pens) for first Dose (Day 1). Then Inject 80mg/0.8mL SC (one 80mg/0.8mL Pen) two weeks after first dose (Day 15). Then inject 40mg/0.4ml SC every OTHER week starting at week 4 (Day 29). **Maintenance Dose:** ☐ Inject 40mg SC (one 40mg/0.4mL Pen) every other week	_____ _____	_____
☐ **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 **Other:** ☐ _____	3 1 _____	_____ _____
☐ **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	
☐ **Stelara®**	☐ 1x 90mg/ml Prefilled Syringe	☐ Inject 90mg SC 8 weeks after initial IV dose and then every 8 weeks thereafter **Other:** ☐ _____	1x90mg/ml PFS _____	_____

Ship to: ☐ Patient ☐ Office ☐ Other

5. Physician Information:

INJECTION TRAINING: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.