BIOMATRIX SpRx

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

TODAY'S DATE ________________

☐ CURRENT PATIENT ☐ NEW PATIENT

PLEASE FAX REFERRAL FORM TO:

- ☐ **BiologicTx - NJ** TEL: 877-567-8087 FAX: 877-567-8089
- ☐ **BiologicTx - CA** TEL: 800-404-1963 FAX: 800-404-4595
- ☐ **BiologicTx - IL** TEL: 888-892-7607 FAX: 877-567-8089
- ☐ **Decillion Healthcare** TEL: 800-622-9321 FAX: 866-548-8849
- ☐ **Elwyn Specialty Care** TEL: 855-359-9679 FAX: 610-545-6030
- ☐ **Factor Support Network** TEL: 877-376-4968 FAX: 805-482-6324
- ☐ **Matrix Health** TEL: 877-337-3002 FAX: 888-385-2805
- ☐ **Med Center Specialty Pharmacy** TEL: 855-633-5633 FAX: 304-344-0655
- ☐ **MedEx BioCare** TEL: 800-962-6339 FAX: 901-382-3091

Patient Name ________ SS# ________ DOB ________ ☐ Male ☐ Female
Street Address ________ Apt# ________ City ________ State ________ Zip ________
Daytime Tel ________ Cell ________ Email ________ Height ________ Weight ________ BSA ________
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone ________
Allergies ________ Comorbidities ________
Current Medications (if necessary, please fax a complete list) ________

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT
________	________	________	________

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ ________ #________	☐ ________ #________	☐ ________ #________
☐ ________ #________	☐ ________ #________	☐ ________ #________
☐ ________ #________	☐ ________ #________	☐ ________ #________

Insured's Name ________ Relation to Patient ________
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ________ Prescription Card ☐ Yes ☐ No If Yes, Carrier ________
Tel ________ Fax ________ Policy/Group# ________
Bin# ________ Pcn# ________ RXID# ________ RX Group# ________

Diagnosis: Crohn's Disease: ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90
Ulcerative Colitis: ☐ K51.20 ☐ K51.80 ☐ K51.90
TB/PPD Test given? ☐ Yes ☐ No Date:________ Chest X-Ray? ☐ Yes ☐ No Results________

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PATIENT TRAINING
Injection teach requested ☐ Yes ☐ No
(Injection Teaching by RN/LPN for 1-2 visits until patient is independent)
Preferred method to contact office:
☐ Phone ☐ Fax OR ☐ Email ________

PRIOR | CURRENT TREATMENTS
☐ Azathioprine ☐ Corticosteroids ☐ 5-ASA
☐ 6-MP ☐ NSAIDS ☐ Methotrexate ☐ Sulfasalazine
☐ Other ________
Dose | Duration ________

CIMZIA
☐ **Starting Dose:** 400 mg subcutaneously initially and at weeks 2 and 4
☐ **Maintenance Dose:** 400 mg subcutaneously every 4 weeks
QTY: 4 week supply Refills: ________

ENTYVIO 300mg
☐ **Starting Dose:** Infuse 300 mg IV at weeks 0, 2, & 6 then maintenance QTY: 3
☐ **Maintenance Dose:** Infuse 300 mg IV every 8 weeks
QTY: ________ Refills: ________

☐ HUMIRA ☐ HUMIRA Citrate-Free
☐ 40mg/0.4mL ☐ 80mg/0.8mL ☐ 20/0.2mL | ☐ PFS ☐ Pens
☐ **Starting Dose:** Day 1: Inject 160 mg subcutaneously
Day 15: Inject 80 mg subcutaneously
Day 29: Maintenance
☐ **Maintenance Dose:** Inject 40 mg/0.8ml subcutaneously every other week
☐ Other ________
QTY: 4 week supply Refills: ________

OTHER ________
Sig ________ QTY: ________ Refills: ________

REMICADE 100 mg vial ☐ MD Office Infusion
Infusion supplies needed ☐ YES ☐ NO
☐ **Starting Dose:** 5 mg/kg ____mg IV on weeks 0, 2 & 6 then,
☐ **Maintenance Dose:** 5 mg/kg ____ mg IV every 8 weeks for ____ infusions
☐ Other ________
QTY: ________ Refills: ________

SIMPONI (golimumab) ☐ SmartJect™ ☐ PFS
☐ **Starting Dose:** 200 mg subcutaneously at week 0, then 100 mg subcutaneously at week 2 **QTY:** 3 (100 mg/mL)
Maintenance Dose:
☐ 100 mg subcutaneously every 4 weeks **QTY:** 1 (100 mg/mL)
☐ 50 mg subcutaneously every 4 weeks **QTY:** 1 (50 mg/0.5mL)
☐ Other ________
QTY: ________ Refills: ________

STELARA ☐ 130 mg/26 mL SD Vial
☐ 45 mg PFS ☐ 90 mg PFS ☐ 45 mg SD Vial
☐ **Starting Dose:** Infuse ____mg IV initially, then Maintenance
☐ **Maintenance Dose:** Inject 90 mg subcutaneously 8 weeks after the initial IV dose, then every 8 weeks
QTY: ________ Refills: ________

Weight of Patient (Kg)	Recommended Dosage	Vials
≤ 55 kg or less	260 mg	2
55 kg to 85 kg	390 mg	3
≥ 85 kg	520 mg	4

XELJANZ *Ulcerative Colitis only* ☐ 5mg tablet ☐ 10mg tablet
☐ **Starting Dose:** ___mg orally twice a day with or without food for ___ weeks
QTY: ________ Refills: ________
☐ **Maintenance Dose:** ___mg orally twice a day
QTY: ________ Refills: ________

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ________ *Dispense as written* **Date** ________
Prescriber's Signature (signature required. NO STAMPS) ________ *Product Substition Permitted* **Date** ________

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