GLEN ROCK
Medical Pharmacy
Part of The Elwyn Pharmacy Group

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

210 Rock Rd | Glen Rock, NJ 07452
866-888-3200 TEL: 201-444-3200 FAX: 201-444-5792

Today's Date

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

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

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#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

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

HUMIRA

☐ **STARTER** Day 1: Inject 160mg (4 pens) SQ.
Day 15: Inject 80mg (2 pens) SQ.
Day 29: maintenance
☐ **MAINTENANCE** Inject (1 Pen) 40mg/0.8ml every other week
☐ Other
QUANTITY 4 week supply Refill X

SIMPONI ® (golimumab) ☐ SmartJect™ ☐ Prefilled Syringe

☐ **STARTER** 200mg SC at week 0, then 100mg SC at week 2 **QTY:** 3 (100 mg/mL)
MAINTENANCE
☐ 100mg SC every 4 weeks **QTY:** 1 (100 mg/mL)
☐ 50mg SC every 4 weeks **QTY:** 1 (50 mg/0.5mL)
☐ Other Refill X

REMICADE 100 mg vial ☐ MD Office Infusion

Infusion supplies needed ☐ YES ☐ NO
☐ **STARTING DOSE:** 5 mg/kg ____mg on week 0, week 2 & week 6 then,
☐ **MAINTENANCE DOSE:** 5 mg/kg _____ mg every 8 weeks for ____ infusions every 8 weeks
☐ Other
QTY _____ Refills _____

CIMZIA

☐ **STARTER** 400mg SQ initially and at week 2 & 4
☐ **MAINTENANCE** 400 mg SQ every 4 weeks
QUANTITY 4 week supply Refill X

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) **Date**

Please fax completed referral form to **Glen Rock Medical Pharmacy** at **201-444-5792** Visit us at **WWW.GLENROCKMEDICALPHARMACY.COM** for online fillable forms.

NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH CROHNS & ULCERATIVE COLITIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc…)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card
  If the only card included is a medical card, please include local pharmacy information
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Recent TB test results and date
- ☐ Previous treatment
- ☐ Symptoms
- ☐ Clinical notes

Fax the requested documentation to (201) 444-5792
Toll Free: 1-866-888-3200 Direct Phone: (201) 444-3200
GlenRockMedicalPharmacy.com

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urac ACCREDITED SPECIALTY PHARMACY

PCAB ACCREDITED Compounding Pharmacy