

FEB 2018

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	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION					
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

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

STARTER: 400mg SQ initially and at week 2 & 4
 MAINTENANCE: 400 mg SQ every 4 weeks
QTY: 4 week supply Refills: _____

ENTYVIO 300mg

STARTER: Infuse 300mg IV at weeks 0, 2, & 6 then maintenance QTY: 3
 MAINTENANCE: Infuse 300 mg IV every 8 weeks
QTY _____ Refills _____

HUMIRA

STARTER: Day 1: Inject 160mg (4 pens) SQ
Day 15: Inject 80mg (2 pens) SQ
Day 29: maintenance
 MAINT.: Inject (1 Pen) SQ 40mg/0.8ml every other week
 Other _____
QTY 4 week supply Refills _____

REMICADE 100 mg vial MD Office Infusion
Infusion supplies needed YES NO
 STARTING: 5 mg/kg _____ mg on weeks 0, 2 & 6 then,
 MAINTENANCE: 5 mg/kg _____ mg
every 8 weeks for _____ infusions every 8 weeks
 Other _____
QTY _____ Refills: _____

SIMPONI (golimumab) SmartJect™ PFS

STARTER: 200mg SQ at week 0, then 100mg SQ at week 2 QTY: 3 (100 mg/mL)
MAINTENANCE:
 100mg SQ every 4 weeks QTY: 1 (100 mg/mL)
 50mg SQ every 4 weeks QTY: 1 (50 mg/0.5mL)
 Other _____
QTY _____ Refills _____

STELARA 130 mg/26 mL SD Vial
 45mg PFS 90mg PFS 45mg SD Vial

STARTER: Infuse _____ mg IV initially, then maintenance
 MAINTENANCE: Inject 90 mg SQ 8 wks after the initial IV dose, then every 8 wks
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

OTHER _____

Sig _____
Qty _____ Refills _____

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** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Glen Rock Medical Pharmacy** at **201-444-5792** Visit **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

www.GlenRockMedicalPharmacy.com

