aleracare
advanced specialty pharmacy

Crohn's Disease
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Considerations

Diagnosis (ICD 10): ◯ K50 Crohn's disease of small intestine without complications

◯ Other (please specify):_____

◯ Previously Tried/Failed Therapies:_____

Medication	Strength/Directions for Use	Qty	Refills
◯ **HUMIRA®**	◯ 40mg SC every 2 weeks ◯ Start: 160mg SC x 1 on week 0, then 80mg SC x 1 on week 1, the 40mg SC every 2 weeks ◯ 80mg SC x 3 doses on days 1, 2 & 15, then 40 mg SC every 2 weeks starting on day 28 ◯ Other		
◯ **CIMZIA®**	◯ 400mg SC every 4 weeks ◯ Start: 400mg SC x 1 on weeks 0, 2, 4 ◯ Other: _____		
◯ **REMICADE®**	◯ Dose: _____ ◯ Weight: _____		
◯ **ENTYVIO®**	◯ 300mg infused intravenously over 30 minutes at 0, 2, 6 weeks, then every 8 weeks thereafter.		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

_____ _____

Prescriber's Signature **Date**