aleracare
advanced specialty pharmacy

Ulcerative Colitis
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 Consideration

Diagnosis (ICD 10) :
- ◯ K51 Ulcerative Colitis
- ◯ Other (please specify): _____

Medication	Dose/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 40mg SC every 2 weeks starting on day 28 ◯ Other: _____		
◯ **SIMPONI®**	◯ Induction: Inject 200gm SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 ◯ Maintenance: 100mg SC every 4 weeks starting at week 6, following induction dose ◯ Other: _____		
◯ **REMICADE®**	◯ Dose: ◯ Weight:		
◯ **UCERIS®**	◯ 9mg tablet once daily by mouth		
◯ **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** _____