aleracare
advanced specialty pharmacy

Ulcerative Colitis

Referral Form

Patient Information

Patient Name: DOB:

Address:

City: State: Zip:

Phone: Alternate Phone: SSN:

Height: Weight: Allergies:

Emergency Contant: Phone:

Is the patient pregnant, planning a pregnancy or nursing: Yes No

Prescriber Information

Prescriber's Name:

NPI#:

DEA#: License#:

Address:

Phone: Fax:

Contact Person:

Does the patient need interpreter services: Yes No

Documentation (Required)

Insurance Card (front and back) Current Medications History/Progress Notes

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

Other: ____

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 ____________________