Inflammatory Bowel Disease (IBD) Referral Form

Phone (888) 370.1724 Fax (402) 896.3774
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information *Please Fax a Copy of Patient's Insurance Card (Front and Back)*

Last Name	First Name	Home Phone	Work/Mobile Phone	Date of Birth

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Gender (M/F)	Weight	Emergency Contact/Phone	Primary Caregiver/Phone

Healthcare Provider Information **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI#*	Nurse/Key Contact	Phone or Pager Number	Email

Clinical Information

Diagnosis: ❑ 555.0 ❑ 555.1 ❑ 555.2 ❑ 555.9 ❑ 556.0 ❑ 556.1 ❑ 556.5 ❑ 556.6 ❑ 556.9 ❑ Other: _____

Date of Diagnosis (or years with disease): _____ **Crohn's Severity:** ❑ Moderate ❑ Moderate to Severe ❑ Severe

Enterocutaneous/Recto Vaginal Fistulas? ❑ Yes ❑ No **Does patient have a latex allergy?** ❑ Yes ❑ No

Prior (FAILED) Therapy: ❑ Humira ❑ Simponi ❑ Remicade ❑ Cimzia ❑ Methotrexate ❑ Corticosteroids ❑ Immunosuppressants (6-MP or other) ❑ Surgery ❑ Other (please list): _____

TB/PPD Test Given? ❑ Yes ❑ No **Date of Negative TB test:** _____ **Hepatitis B ruled out?** ❑ Yes ❑ No **If no, has treatment been started?** ❑ Yes ❑ No

Delivery/Injection Training Information

Today's Date	Date Shipment Needed	Deliver to: ❑ Home ❑ Facility (address listed above)	Special Instructions

****Amber Pharmacy to coordinate injection training/home health nurse visit as necessary?** ❑ Yes ❑ No ❑ Injection Training is not necessary

❑ Medication to be administered at facility ❑ Referred to alternate trainer ❑ Patient already independent ❑ Provider office to train or has trained patient

Medication	Dose/Strength	Directions for Use	Qty	Refills
❑ **Cimzia®** **If prescribing Cimzia® vials, please document injection training information above****	**Induction Dose:** ❑ Cimzia® Starter Kit (6x200mg Prefilled Syringes) ❑ Cimzia® 2 x 200mg Lyophylized Vials (three packs)	Inject 400mg SC initially, repeat dose 2 and 4 weeks after initial dose	QS	0
	Maintenance Dose: ❑ Cimzia® 2 x 200mg Prefilled Syringes ❑ Cimzia® 2 x 200mg Lyophylized Vials	Inject 400mg SC every 4 weeks	28 day supply	
❑ **Humira®**	**Induction Dose:** ❑ Humira® Crohn's Disease/Ulcerative Colitis Starter Pack	❑ Inject 160mg (4x40mg pens) SC as a single dose on Day 1, **OR** ❑ 80mg (2x40mg pens) SC daily over 2 consecutive days; then inject 80mg (2x40mg pens) SC two weeks later (on Day 15)	#1 Starter Package (6 pens)	0
	Maintenance Dose: ❑ 40mg/0.8ml Prefilled syringe ❑ 40mg/0.8ml Pen	Inject 40mg SC every other week	2	
❑ **Remicade®**	❑ 100mg Powder Vial (Patient Weight: _____) **Drug will be dispensed to the appropriate healthcare provider**	**Induction Dose:** ❑ Infuse 5mg/kg IV at 0, 2 and 6 weeks	QS	0
		Maintenance Dose: ❑ Infuse 5mg/kg IV every 8 weeks ❑ Infuse _____ mg/kg IV every 8 weeks (dose may be increased to 10mg/kg in patients who respond but then lose their response).	QS	
❑ **Simponi®**	❑ 100mg/1ml Prefilled syringe ❑ 100mg/1ml SmartJect® Autoinjector	**Induction Dose:** ❑ Inject 200mg (2x100mg syringes/pens) SC at week 0; then inject 100mg SC at week 2	3	0
		Maintenance Dose: ❑ Inject 100mg SC every 4 weeks	1	

****When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards****

Physician Signature:_____ ❑ **DAW** (Dispense as Written) **Date** ____/____/____

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