Elwyn SPECIALTY CARE
A BIOMATRIX Company

FEB 2018

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

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

	#		#		#
☐ ______	#______	☐ ______	#______	☐ ______	#______
☐ ______	#______	☐ ______	#______	☐ ______	#______
☐ ______	#______	☐ ______	#______	☐ ______	#______
☐ ______	#______	☐ ______	#______	☐ ______	#______
☐ ______	#______	☐ ______	#______	☐ ______	#______

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 Elwyn Specialty Care 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 **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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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 ***(610) 545-6030***

Toll Free: ***1-855-ELWYN-RX*** *(359-9679)* ***Direct Phone:*** ***(610) 545-6040***

ElwynSpecialtyCare.com

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