

**CROHN'S & ULCERATIVE COLITIS REFERRAL FORM**

**SUPERIOR BIOLOGICS**  
Fax Referral To: 914-747-1170  
Phone: 855-747-1150



Date: \_\_\_\_\_

Needs by Date: \_\_\_\_\_ Ship to  Patient's Home  Prescriber 1<sup>st</sup> Order Only  Prescriber All Orders

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender:  M  F

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
DEA#: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)**

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_  
Prescription Card: \_\_\_\_\_ ID#: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_ Group: \_\_\_\_\_

**DIAGNOSIS & CLINICAL ASSESSMENT (Fill in below or attach lab work)**

New to Therapy  Currently on Therapy | Start Date: \_\_\_\_\_  Physician Provides Injection Training | Injection Date: \_\_\_\_\_  
**Primary Diagnosis Code & Condition:** \_\_\_\_\_ **Date of Diagnosis:** \_\_\_\_\_  
**TB Test Results & Date:** \_\_\_\_\_ **Current Weight:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_  
 New Therapy Induction  Therapy Change  Remicade Therapy Continuation, Weeks Completed:  0  2  4  6 Date: \_\_\_\_\_  
 Inadequate Response to Methotrexate (Dose: \_\_\_\_\_)  Unresponsive to Conventional Treatment, Other Therapies: \_\_\_\_\_

**Cimzia® (certolizumab pegol)**

Starter Kit (6) 200mg Prefilled Syringes  
 2 x 200mg Vials  
 2 x 200mg Prefilled Syringes  
**Dose / Directions / Frequency:**  
 Induction Dose: 2 x 200mg injections at Week 0, 2 and 4  
 Maintenance Dose: 400 mg s-c monthly  
 Other: \_\_\_\_\_  
QTY: \_\_\_\_\_ Refill: \_\_\_\_\_

**Entyvio® (vedolizumab)**

300 mg Vial  
**Dose / Directions / Frequency:**  
 Induction Dose: 300mg IV at wk 0, 2 & 6  
 Maintenance Dose: 300mg IV every 8 wks  
 Other: \_\_\_\_\_  
QTY: \_\_\_\_\_ Refill: \_\_\_\_\_

**Humira® (adalimumab)**

Crohn's Starter Kit, 6 x 40mg pens  
 Pediatric Crohn's Starter Kit, 3 x 40mg PFS  
 40mg Pens  40 mg PFS  
 20mg pediatric PFS  10mg pediatric PFS  
**Dose / Directions / Frequency:**  
 Induction Dose: Adults & Children >= 88lbs; 160mg (4 x 40mg injections in one day or 2 x 40mg injections per day for two consecutive days); Second dose two weeks later (Day 15) 80mg  
 Induction dose: Children < 88lbs; 80mg (2 x 40mg injections in one day) Second dose two weeks later (Day 15) 40mg  
 Maintenance: \_\_\_\_\_mg every other week  
 Other: \_\_\_\_\_  
QTY: \_\_\_\_\_ Refill: \_\_\_\_\_  
**Step Therapies:**  Therapy tried and failed  
Therapy: \_\_\_\_\_ Date: \_\_\_\_\_  
Therapy: \_\_\_\_\_ Date: \_\_\_\_\_  
Therapy: \_\_\_\_\_ Date: \_\_\_\_\_

**Stelara® (ustekinumab)**

2 x 130mg/26mL  3 x 130mg/26mL  
 4 x 130mg/26mL  1 x 90mg/mL PFS  
**Dose / Directions / Frequency:**  
 Infuse 260mg intravenously over no less than one hour (<55kg)  
 Infuse 390mg intravenously over no less than one hour (55kg to 85kg)  
 Infuse 520mg intravenously over no less than one hour (>85kg)  
 Inject 90mg SQ 8 weeks post-initial IV dose, then q 8 weeks thereafter  
QTY: \_\_\_\_\_ Refill: \_\_\_\_\_

**Simponi®**

Auto Injection: \_\_\_\_\_ 50mg \_\_\_\_\_ 100mg  
 Syringe: \_\_\_\_\_ 50mg \_\_\_\_\_ 100mg

**Dose / Directions / Frequency:**  
 Induction Dose: 200mg s-c initially then 100mg 2 weeks later  
 Maintenance Dose: 100mg s-c Q 4 wks  
 Other: \_\_\_\_\_  
QTY: \_\_\_\_\_ Refill: \_\_\_\_\_

**Remicade® (infliximab)**

100 mg Vial **SIG:** \_\_\_\_\_  
QTY: \_\_\_\_\_ Refill: \_\_\_\_\_

**Other/Notes:**  
\_\_\_\_\_  
\_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **DAW (Dispense as Written)**  Y  N **Date:** \_\_\_\_\_

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