


<b>Crohn's and Ulcerative Colitis Referral Form</b>	<b>SUPERIOR BIOLOGICS</b> Fax Referral To: 914-747-1170 Phone: 855-747-1150	
Date: _____		

Patient Information	Prescriber Information
<b>Please complete the following or send patient demographic sheet</b> Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA: _____ NPI #: _____ Contact Person: _____

Insurance Information	
Primary Insurance: _____ ID#: _____ Group: _____	Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____	

**Medical Information (Section must be completed to process prescription) (Attach separate sheet if needed)**

Prior Authorization Insurance Number: _____	
Diagnosis - Please include diagnosis name with ICD-10 code	Therapy Details: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
<input type="checkbox"/> K50.00 Crohn's disease of small intestines without complications <input type="checkbox"/> K50.8 Crohn's disease of both intestines without complications <input type="checkbox"/> K50.10 Crohn's disease of large intestines without complications <input type="checkbox"/> K50.00 Crohn's disease, unspecified, without complications <input type="checkbox"/> K20.0 Eosinophilic Esophagitis <input type="checkbox"/> Other diagnosis: ICD-10 code _____ Description _____ Date of Description _____ Has a TB test been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the Patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date _____ Review Date _____	Weight _____ kg/lbs Height _____ cm/in Allergies _____ Lab Data _____ Prior Therapies _____ Concomitant Medications _____ Additional Comments _____ Injection Training Required? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Prescription Information**

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/mL Vial Kit <input type="checkbox"/> 200mg/mL Starter Kit <input type="checkbox"/> 200mg/mL prefilled Syringe	<input type="checkbox"/> <b>Loading Dose:</b> Inject 400mg SUBQ at Weeks 0, 2, and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 200mg SUBQ every 2 weeks		
<input type="checkbox"/> Dupixent	<input type="checkbox"/> PFS with needle shield 300 mg/2 mL <input type="checkbox"/> Prefilled Pen 300 mg/2 mL	<input type="checkbox"/> Inject 300 mg SUBQ every week		
<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> <b>Loading Dose:</b> Inject 300mg IV over 30 minutes at Weeks 0, 2, and 6. <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse 300mg IV over 30 minutes every 8 weeks		
<input type="checkbox"/> Humira <input type="checkbox"/> Adalimumab (biosimilar)	<b>Starter Kits:</b> <input type="checkbox"/> 80mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) <b>Maintenance:</b> <input type="checkbox"/> 40mg/0.4mL Pre-Filled Pen (Citrate Free) <input type="checkbox"/> 40mg/0.4mL Pre-Filled Syringe (Citrate Free) <input type="checkbox"/> Other: _____	<b>Adult:</b> <input type="checkbox"/> <b>Loading Dose:</b> Inject 160mg SUBQ on Day 1, then 80mg on Day 15 (two weeks later) <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 40mg SUBQ every other week (starting Day 29) <b>Pediatric (&gt;6 years and adolescents) 17kg to &lt; 40kg</b> <input type="checkbox"/> <b>Loading Dose:</b> Inject 80mg SUBQ on Day 1, 40mg on Day 15 (two weeks later) <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 20mg SUBQ every other week (starting Day 29) <b>Pediatric (&gt;6 years and adolescents) &gt; 40kg</b> <input type="checkbox"/> <b>Loading Dose:</b> Inject 160mg SUBQ on Day 1, 80mg on Day 15 (two weeks later) <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 40mg SUBQ every other week (starting Day 29)		

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

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**Crohn's and Ulcerative Colitis Referral Form**

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



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

**Patient Information**

Please complete the following or send patient demographic sheet

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

**Prescriber Information**

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

**Insurance Information**

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

**Medical Information (Section must be completed to process prescription)**

**(Attach separate sheet if needed)**

Prior Authorization Insurance Number: \_\_\_\_\_

**Diagnosis** - Please include diagnosis name with ICD-10 code  
 K50.00 Crohn's disease of small intestines without complications  
 K50.8 Crohn's disease of both intestines without complications  
 K50.10 Crohn's disease of large intestines without complications  
 K50.00 Crohn's disease, unspecified, without complications  
 Other diagnosis: ICD-10 code \_\_\_\_\_  
 Description \_\_\_\_\_ Date of Description \_\_\_\_\_  
 Has a TB test been performed?  Yes  No  
 Does the Patient have an active infection?  Yes  No  
 Start Date \_\_\_\_\_ Review Date \_\_\_\_\_

**Therapy Details:**  New  Reauthorization  Restart  
 Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in  
 Allergies \_\_\_\_\_ Lab \_\_\_\_\_  
 Data \_\_\_\_\_ Prior \_\_\_\_\_  
 Therapies \_\_\_\_\_  
 Concomitant Medications \_\_\_\_\_  
 Additional Comments \_\_\_\_\_  
 Injection Training Required?  Yes  No

**Prescription Information**

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> <b>Loading Dose:</b> Infuse 5mg/kg at Weeks 0, 2, and 6 <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse 5mg/kg every 8 weeks		
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> <b>Induction Therapy</b> – 45 mg tablet <input type="checkbox"/> <b>Maintenance Therapy</b> – 15 mg or 30 mg tablets	<input type="checkbox"/> <b>Induction Therapy:</b> 45 mg PO daily x 8 weeks. <b>Maintenance Therapy:</b> <input type="checkbox"/> 15 mg PO daily <input type="checkbox"/> 30 mg PO daily		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100mg/mL Smart Ject Auto Injector <input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> <b>Loading Dose:</b> Inject 200 mg SUBQ at Week 0 then 100mg at Week 2 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 100mg SUBQ every 4 weeks		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg/26mL solution single dose vial <input type="checkbox"/> 90mg/mL Prefilled Syringe Date of Initial Infusion: _____	<input type="checkbox"/> <b>Loading Dose:</b> Infuse: <input type="checkbox"/> 250mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg as initial IV dose as directed by prescriber <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 90mg SUBQ every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> <b>Initiation Therapy</b> – 600 mg/10 mL single use vial. <input type="checkbox"/> <b>Ongoing Therapy</b> – 360 mg/2.4 mL prefilled cartridge with On-Body Injector	<input type="checkbox"/> <b>Initiation Therapy</b> – <input type="checkbox"/> Inject 600 mg IV over at least 1 hour at Weeks 0, 4, 8. 1 vial/week. <input type="checkbox"/> <b>Ongoing Therapy</b> – Week 12 – Inject 360 mg SUBQ and every 8 weeks thereafter. 1 device with prefilled cartridge.		
<input type="checkbox"/> Tremfya	<b>Subcutaneous Injection:</b> <input type="checkbox"/> 100 mg/mL in a single-dose One-Press patient-controlled injector <input type="checkbox"/> 200 mg/2 mL in a single-dose prefilled pen (Tremfya Pen) <input type="checkbox"/> 100 mg/mL in a single-dose prefilled syringe <input type="checkbox"/> 200 mg/2 mL in a single-dose prefilled syringe <b>Intravenous Infusion:</b> <input type="checkbox"/> 200 mg/20 mL (10 mg/mL) solution in a single-dose vial	<b>Induction:</b> <input type="checkbox"/> 200 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, Week 8 <b>Maintenance:</b> <input type="checkbox"/> 100 mg administered by subcutaneous injection at Week 16, and every 8 Week thereafter, or 200 mg administered by subcutaneous injection at Week 12, and every 4 Weeks thereafter. Use the lowest effective recommended dosage to maintain therapeutic response.		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet <input type="checkbox"/> 11mg XR tablet <input type="checkbox"/> 22mg XR tablet	<input type="checkbox"/> <b>Loading Dose:</b> <input type="checkbox"/> 10mg twice daily for 8 weeks <input type="checkbox"/> XR: 22mg once for 8 weeks <input type="checkbox"/> <b>Maintenance Dose:</b> <input type="checkbox"/> 5mg twice daily <input type="checkbox"/> XR: 11mg once daily <input type="checkbox"/> 10mg twice daily <input type="checkbox"/> XR: 22mg once daily		

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

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