

Crohn's and Ulcerative Colitis Referral Form	Superior Pharmacy Solutions Fax Referral To: 866-416-3656 Phone: 866-416-3655			
Date: _____				
Patient Information		Prescriber 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 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 ☐ K50.90 Crohn's disease, unspecified, without complications ☐ K20.0 Eosinophilic Esophagitis ☐ 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
☐ Cimzia	☐ 200mg/mL Vial Kit ☐ 200mg/mL Starter Ki ☐ 200mg/mL prefilled Syringe	☐ Loading Dose: Inject 400mg SUBQ at Weeks 0, 2, and 4 ☐ Maintenance Dose: Inject 200mg SUBQ every 2 weeks		
☐ Dupixent	☐ PFS with needle shield 300 mg/2 mL ☐ Prefilled Pen 300 mg/2 mL	☐ Inject 300 mg SUBQ every week		
☐ Entyvio	☐ 300mg vial	☐ Loading Dose: Inject 300mg IV over 30 minutes at Weeks 0, 2, and 6. ☐ Maintenance Dose: Infuse 300mg IV over 30 minutes every 8 weeks		
☐ Humira ☐ Adalimumab (biosimilar)	Starter Kits: ☐ 80mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) Maintenance: ☐ 40mg/0.4mL Pre-Filled Pen (Citrate Free) ☐ 40mg/0.4mL Pre-Filled Syringe (Citrate Free) ☐ Other: _____	Adult: ☐ Loading Dose: Inject 160mg SUBQ on Day 1, then 80mg on Day 15 (two weeks later) ☐ Maintenance Dose: Inject 40mg SUBQ every other week (starting Day 29) Pediatric (>6 years and adolescents) 17kg to < 40kg ☐ Loading Dose: Inject 80mg SUBQ on Day 1, 40mg on Day 15 (two weeks later) ☐ Maintenance Dose: Inject 20mg SUBQ every other week (starting Day 29) Pediatric (>6 years and adolescents) > 40kg ☐ Loading Dose: Inject 160mg SUBQ on Day 1, 80mg on Day 15 (two weeks later) ☐ Maintenance Dose: 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 Pharmacy Solutions Fax Referral To: 866-416-3656 Phone: 866-416-3655		 SUPERIOR BIOLOGICS	
Date: _____					
Patient Information			Prescriber Information		
Please complete the following or send patient demographic sheet			Prescriber Name: _____		
Patient Name: _____			Address: _____ City, _____		
Address: _____			State, Zip: _____		
City, State, Zip: _____			Phone: _____		
Home Phone: _____			Fax: _____		
Cell Phone: _____			DEA: _____ NPI #: _____		
DOB: _____ Gender: ☐ M ☐ F			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: ☐ New ☐ Reauthorization ☐ Restart		
☐ 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 _____			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
☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ 100mg Vial	☐ Loading Dose: Infuse 5mg/kg at Weeks 0, 2, and 6 ☐ Maintenance Dose: Infuse 5mg/kg every 8 weeks			
☐ Rinvoq	☐ Induction Therapy – 45 mg tablet ☐ Maintenance Therapy – 15 mg or 30 mg tablets	☐ Induction Therapy: 45 mg PO daily x 8 weeks. Maintenance Therapy: ☐ 15 mg PO daily ☐ 30 mg PO daily			
☐ Simponi	☐ 100mg/mL Smart Ject Auto Injector ☐ 100mg/mL Prefilled Syringe	☐ Loading Dose: Inject 200 mg SUBQ at Week 0 then 100mg at Week 2 ☐ Maintenance Dose: Inject 100mg SUBQ every 4 weeks			
☐ Stelara	☐ 130mg/26mL solution single dose vial ☐ 90mg/mL Prefilled Syringe Date of Initial Infusion: _____	☐ Loading Dose: Infuse: ☐ 260mg ☐ 390mg ☐ 520mg as initial IV dose as directed by prescriber ☐ Maintenance Dose: Inject 90mg SUBQ every 8 weeks (begin dosing 8 weeks after the IV induction dose)			
☐ Skyrizi	☐ Initiation Therapy – 600 mg/10 mL single use vial. ☐ Ongoing Therapy: ☐ 180 mg/1.2 mL prefilled cartridge with On-Body Injector ☐ 360 mg/2.4 mL prefilled cartridge with On-Body Injector	☐ Initiation Therapy – ☐ Inject 600mg IV over at least 1 hour at Weeks 0, 4, 8, 1 vial/week. ☐ Ongoing Therapy - Week 12 - Inject 180mg or 360mg SUBQ and every 8 weeks thereafter. 1 device with prefilled cartridge.			
☐ Tremfya	Subcutaneous Injection: ☐ 100 mg/mL in a single-dose One-Press patient-controlled injector ☐ 200 mg/2 mL in a single-dose prefilled pen (Tremfya Pen) ☐ 100 mg/mL in a single-dose prefilled syringe ☐ 200 mg/2 mL in a single-dose prefilled syringe Intravenous Infusion: ☐ 200 mg/20 mL (10 mg/mL) solution in a single-dose vial	Induction: ☐ 200 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, Week 8 Maintenance: ☐ 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.			
☐ Xeljanz	☐ 5mg tablet ☐ 10mg tablet ☐ 11mg XR tablet ☐ 22mg XR tablet	☐ Loading Dose: ☐ 10mg twice daily for 8 weeks ☐ XR: 22mg once for 8 weeks ☐ Maintenance Dose: ☐ 5mg twice daily ☐ XR: 11mg once daily ☐ 10mg twice daily ☐ XR: 22mg once daily			
Prescriber Signature: _____ DAW (Dispense as Written) ☐ Y ☐ N Date: _____					

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