Crohn's and Ulcerative Colitis Referral Form

Date: _____

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

SUPERIOR BIOLOGICS

Patient Information

Please complete the following or send patient demographic sheet

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate 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)

Diagnosis:

☐ K50.0 - Crohn's disease of small intestine
☐ K50.1 - Crohn's disease of large intestine
☐ K50.8 - Crohn's disease of both small and large intestine
☐ K50.9 - Crohn's disease, unspecified
☐ K51 - Ulcerative colitis
☐ K51.9 - Ulcerative colitis, unspecified
☐ Other diagnosis: ICD-10 code _____
Description _____ Date of Description _____
Is patient up to date on all required labs/vaccinations as required by therapy? ☐ Yes ☐ No

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
☐ Home ☐ Office

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
☐ Entyvio	☐ 300 mg vial	☐ **Loading Dose IV**: 300mg over 30 minutes at Week 0, 2, and 6. ☐ **Maintenance Dose IV**: 300mg over 30 minutes every 8 weeks		
☐ Omvoh	**CD:** ☐ 300mg/15mL vial (IV) ☐ 200mg/2mL + 100mg/mL PFP (SUBQ) ☐ 200mg/2mL + 100mg/mL PFS (SUBQ) **UC:** ☐ 300mg/15mL vial (IV) ☐ 100mg/mL + 100mg/mL PFP (SUBQ) ☐ 100mg/mL + 100mg/mL PFS (SUBQ)	**CD:** ☐ **Loading Dose -** 900mg IV over at least 90 minutes at Weeks 0,4, & 8 ☐ **Maintenance Dose**: 300mg SUBQ (consecutive injections of 100mg + 200mg) **UC:** ☐ **Loading Dose**: 300mg IV over at least 30 minutes at Weeks 0, 4, & 8 ☐ **Maintenance Dose**: 200mg SUBQ (consecutive injections of 100mg + 100mg)		
☐ Remicade ☐ Avsola ☐ Inflectra ☐ Renflexis ☐ Infliximab	☐ 100 mg Vial	☐ **Loading Dose IV**: 5mg/kg at Weeks 0, 2, and 6 ☐ **Maintenance Dose IV**: 5mg/kg every 8 weeks (Starting Week 14)		
☐ Stelara ☐ Approve switch to preferred biosimilar	**Loading Dose IV based on weight:** ☐ 260mg ☐ 390mg ☐ 520mg **Maintenance Dose SUBQ:** ☐ 90mg	**Loading Dose IV based on weight:** ☐ 260mg ☐ 390mg ☐ 520mg **Maintenance Dose SUBQ:** ☐ 90mg q 8 weeks (beginning 8 weeks after loading dose)		

Prescriber Signature: _____ **DAW (Dispense as Written)** ☐Y ☐N **Date:** _____

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Description _____ Date of Description _____
Is patient up to date on all required labs/vaccinations as required by therapy? ☐ Yes ☐ No

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
☐ Home ☐ Office

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
☐ Skyrizi	**IV**: ☐ 600 mg/10 mL vial **SUBQ:** ☐ 180 mg/1.2 mL PFS ☐ 180 mg/1.2 mL OBI ☐ 360 mg/2.4 mL OBI	**Loading Dose (CD):** ☐ 600mg IV over at least 1 hour at Weeks 0, 4, & 8 **Loading Dose (UC):** ☐ 1200mg IV over least 2 hours at Weeks 0, 4, & 8 **Maintenance Dose** ☐ 180 mg SUBQ at Week 12, then q 8 weeks thereafter ☐ 360 mg SUBQ at Week 12, then q 8 weeks thereafter		
☐ Tremfya	**IV:** ☐ 200 mg/20 mL vial **SUBQ:** ☐ 100 mg/mL PFS ☐ 100 mg/mL PFP ☐ 100 mg/mL OBI ☐ 200 mg/2mL PFS ☐ 200 mg/2mL PFP	**Loading Dose**: ☐ 200mg IV over at least 1 hour on Weeks 0, 4, & 8 ☐ 400mg SUBQ on Weeks 0, 4, & 8 **Maintenance Dose**: ☐ 100mg SUBQ at Week 16, and every 8 weeks thereafter ☐ 200mg SUBQ at Week 12, then every 4 weeks thereafter		
☐ Tysabri ☐ Tyruko ☐ Approve switch to preferred biosimilar	☐ 300mg IV over 1 hour every 4 weeks	☐ IV: 300mg over 1 hour q 4 weeks		

Prescriber Signature: _____ **DAW (Dispense as Written)** ☐Y ☐N **Date:** _____