HealthQuest
Infusion & Specialty

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CROHN'S DISEASE REFERRAL FORM

E-SCRIPTS: NCPDP# 5902944 NPI# 1720383003

ACHC ACCREDITED

DATE _____ DATE NEEDED _____

SHIP TO: ☐ Patient ☐ Physician's Office ☐ HealthQuest Infusion

Please fax completed form along with copy of patient's insurance cards and any labs to 866.612.3437

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____ E-mail _____
Date of Birth _____ SS # _____
☐ Female
☐ Male

Prescriber's Name _____
License # _____ DEA # _____
NPI # _____ UPIN # _____
Practice Name _____
Office Contact _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

DIAGNOSIS

Patient: Wt._____ Ht._____ Allergies: ☐ Latex ☐ Other, specify _____

ICD-10 DIAGNOSIS CODE ☐ K50.00 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other: _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed: _____
Patient currently on therapy? ☐ Yes ☐ No Types/Medications: _____
Current medication, including OTC: _____ **PPD (TB Test):** ☐ Yes ☐ No Date: _____

PRESCRIPTION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Cimzia®	☐ 200mg PFS	☐ Initial dose: 400mg SQ (2 injections) at wks. 0, 2, and 4 ☐ Other: _____ ☐ Maintenance Dose: 400mg SQ every 4 wks. ☐ Other: _____	☐ 1 wk. supply ☐ 2 wks. supply	
Entyvio®	☐ 300mg in a single-dose ☐ Vial in individual carton	☐ Recommended dosage in UC and CD: 300mg infused IV over 30 min. at 0, 2, and 6 wks., then every 8 wks. thereafter		
Humira®	☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pen ☐ 20mg/0.4mL PFS	☐ Initial dose: 160mg SQ on Day 1, 80mg SQ on Day 15, 40mg SQ every other wk. ☐ Other: _____ ☐ Maintenance Dose: 40mg SQ every other wk. ☐ Other: _____	☐ 1 wk. supply ☐ 2 wks. supply	
Remicade®	☐ 100mg Vial ☐ 5mg/kg ☐ _____mg/kg	☐ IV on wks 0, 2, and 6 ☐ IV every 8 wks. ☐ IV every_____wks.	☐ # of vials: _____	
Simponi®	☐ 100mg PFS ☐ 100mg Autoinject	☐ Initial Dose: 200mg SQ at wk. 0 and 100mg SQ at wk. 2 ☐ Maintenance Dose: 100mg SQ every 4 wks. ☐ Other: _____	☐ 1 wk. supply ☐ 2 wks. supply	
Stelara®	☐ 130mg/26mL (5mg/mL) ☐ IV single-dose Vial *Date infusion was completed/scheduled:* _____ (required) ☐ 90mg/mL SUBCUTANEOUS dose in a single-dose pre-filled syringe	Single IV Induction Dose: ☐ ≤ 55kg: 260mg at wk. 0: # of vials to be used = 2 ☐ > 55kg to 85kg: 390mg at wk. 0: # of vials to be used = 3 ☐ > 85kg: 520mg at wk. 0: # of vials to be used = 4 ☐ 90mg SUBCUTANEOUS dose 8 wks. after the initial IV induction dose. Then every 8 wks. thereafter. ☐ Other: _____	☐ 2 vials ☐ 3 vials ☐ 4 vials	
Tysabri®	Available only through the TOUCH prescribing program. Use Tysabri® enrollment form and indicate HealthQuest Infusion Services as your preferred pharmacy provider.			

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____