DELMARVA SPECIALTY PHARMACY AT WOODBROOKE

CROHN'S & ULCERATIVE COLITIS REFERRAL FORM

1615 Tree Sap Court Salisbury, MD 21804
Tel 410.677.0561 Fax 410.677.0562

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

Diagnosis: Crohn's Disease ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Ulcerative Colitis ☐ K51.20 ☐ K51.80 ☐ K51.90

TB/PPD Test given? ☐ Yes ☐ No Chest X-Ray ☐ Yes ☐ No Results

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRIOR | CURRENT TREATMENTS

Treatment	Dose | Duration
☐ Azathioprine	
☐ Corticosteroids	
☐ Remicade	
☐ 5-ASA	
☐ 6-MP	
☐ NSAIDS	
☐ Methotrexate	
☐ Sulfasalazine	
☐ Other: List	

HUMIRA

☐ **STARTER** Day 1: Inject 160mg (4 pens) SQ.
Day 15: Inject 80mg (2 pens) SQ.
Day 29: maintenance

☐ **MAINTENANCE** Inject (1 Pen) 40mg/0.8ml every other week

☐ Other

QUANTITY 4 week supply Refill X

CIMZIA

☐ **STARTER** 400mg SQ initially and at week 2 & 4

☐ **MAINTENANCE** 400 mg SQ every 4 weeks

QUANTITY 4 week supply Refill X

REMICADE 100 mg vial

☐ MD Office Infusion

☐ Home Infusion

Infusion supplies needed ☐ YES ☐ NO

☐ **STARTING DOSE:**
5 mg/kg ____mg on week 0, week 2 & week 6 then,

☐ **MAINTENANCE DOSE:**
5 mg/kg _____ mg every 8 weeks for ____ infusions every 8 weeks

☐ Other

QTY _____ Refills _____

By signing this form and utilizing our services, you are authorizing Delmarva Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) **Date**

Please fax completed referral form to **Delmarva Specialty Pharmacy** at **410.677.0562** Visit us at **WWW.DELMARVAPHARMACY.COM** for online fillable forms.