RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

Crohn's / GI / UC Prescriptions Referral Form

Send your Rx to:

Select Location

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location): _____ Injection training by pharmacy? ☐

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lbs. ☐ kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

2. Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

3. Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

4. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Diagnosis: _____ ICD-10: _____

5. Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Cimzia®**	☐ Prefilled Syringes (2x200mg) (or) ☐ Lyophilized vials (2 x 200mg)	☐ **Induction Dose:** Inject 400mg SC at weeks 0, 2, and 4 ☐ **Maintenance Dose:** 400mg SC every 4 weeks		
☐ **Humira®** ☐ Injection training from My Humira *(patient must sign below)*	☐ 20mg Pen ☐ 20mg Prefilled Syringe ☐ 40mg Pen ☐ 40mg Prefilled Syringe ☐ Starter Pack	☐ **Induction Dose:** Inject 160mg SC (four 40mg Pens) for first Dose (Day 1). Then Inject 80mg SC (two 40mg Pen) two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29) ☐ **Maintenance Dose:** Inject 40mg SC (one 40mg Pen) every other week		
☐ **Xifaxan®**	☐ 200mg tabs ☐ 550mg tabs	Take _____ tablets _____ times per day		
☐ **Remicade®**	☐ 100mg vial			
☐ **Simponi®**	☐ 100mg SmartJect® ☐ 100mg Pre-filled Syringe	☐ **Induction Dose:** Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 ☐ **Maintenance Dose:** 100mg SC every 4 weeks starting at week 6, after Induction dose	3 1	
☐ Entyvio®	☐ 300mg vial			
☐ Dificid®	☐ 200mg tabs	☐ Take 1 tablet twice daily with or without food for 10 days	20 Tablets	
☐				
☐				

6. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature _____ **Date** _____

7. Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ **Date** _____ **Substitution Permissible** _____ **Date** _____

# of Prescriptions: _____

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.