Riverview PHARMACY
"Big Enough to Serve You...
Small Enough to Know You..."

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CROHN'S DISEASE & ULCERATIVE COLITIS REFERRAL FORM

Today's Date _____ /_____ /_____ Are you a new patient? ☐ Yes ☐ No
Patient Name _____ DOB _____ /_____ /_____
Emergency Phone _____ Date Needed _____ /_____ /_____
Address Line 1 _____
Address Line 2 _____
City _____ State _____ Zip _____
Phone _____ Cell _____
Email Address _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at
☐ Physician Office ☐ Riverview Pharmacy ☐ Valley Pharmacy
Allergies _____
Comorbidities _____
Current Medications (please fax a complete list if necessary) _____

ICD-10 Diagnosis Code: Ulcerative Colitis ☐ K51.20 ☐ K51.80 ☐ K51.90
Crohn's Disease ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90
B/PPD Test given? ☐ Yes ☐ No Chest X-Ray ☐ Yes ☐ No
Results _____
Has patient been on therapy and relapsed? ☐ Yes ☐ No
List of medication(s) _____
Currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop the medication(s) before starting the new medication? ☐ Yes ☐ No
List of medication(s) to be discontinued _____

Insured's Name _____ Relation _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare # _____
Prescription Card ☐ Yes ☐ No If yes, Carrier _____
Phone _____ Fax _____
Policy/Group# _____
Bin# _____ PCN# _____
RXID# _____ RX Group# _____

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

Please sign and fax completed referral form to Riverview Pharmacy at **973-831-4081**
For this and other referral forms in online formats, visit **www.RiverviewPharmacyNJ.com**

Prescriber's Signature _____ Date _____ /_____ /_____
(actual signature required)

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRIOR|CURRENT TREATMENTS

☐ Azathioprine ☐ Corticosteroids ☐ 5-ASA ☐ 6-MP
☐ NSAIDS ☐ Methotrexate ☐ Sulfasalazine
☐ Other _____
Dose | Duration _____
_____

REMICADE 100 mg vial

☐ MD Office 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 _____

SIMPONI® (golimumab) ☐ SmartJect™ ☐ Prefilled Syringe

☐ **STARTER** 200mg SC at week 0, then 100mg SC at week 2 **QTY:** 3 (100 mg/mL)
MAINTENANCE
☐ 100mg SC every 4 weeks **QTY:** 1 (100 mg/mL)
☐ 50mg SC every 4 weeks **QTY:** 1 (50 mg/0.5mL)
☐ Other _____ Refills_____

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 _____
QTY 4 week supply Refills _____

CIMZIA

☐ **STARTER** 400mg SQ initially and at week 2 & 4
☐ **MAINTENANCE** 400 mg SQ every 4 weeks
QTY 4 week supply Refills _____