



Phone: 1-888-315-3395  
 Fax: 1-888-315-3270

## Crohn's Disease Referral Form

Attn: \_\_\_\_\_

Today's Date: \_\_\_\_\_  
 Date Shipment Needed: \_\_\_\_\_  
 Ship To:  Patient  Physician  
 Nursing needed  Training needed  
 Permission to contact pt:  Yes  No  
 \* All the supplies including syringes and needles will be dispensed if needed.

### General Information

Patient Name: _____	Physician Name: _____
Address: _____	Practice Name/Hospital: _____
City: _____ State: _____ Zip: _____	Address: _____
Home Phone: _____	City: _____ State: _____ Zip: _____
Work Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Soc. Sec #: _____ - _____ - _____ Date of Birth: _____	State Lic #: _____ DEA #: _____
Allergies: _____	NPI #: _____
<b>Weight:</b> _____ <b>Height:</b> _____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	Nurse/Key Office Contact: _____

### Statement of Medical Necessity

Primary Diagnosis: <input type="checkbox"/> CROHN'S DISEASE (ICD-9: 555.90) <input type="checkbox"/> OTHER: _____ ICD-9: _____	Secondary Diagnosis: _____ ICD 9 Code: _____
---	---

### Insurance Information

Primary Insurance: _____	Cardholder Name: _____	Secondary Insurance: _____
Employer: _____	ID#: _____	ID#: _____ Group#: _____
Phone: _____	Group#: _____	Phone: _____

### Prescription Information

<input type="checkbox"/> <b>Humira Crohn's Disease Starter Package</b> SIG: <input type="checkbox"/> Inject 160mg (4 PENS) SQ on DAY 1, then 80mg (2 PENS) SQ on DAY 15, and then 40mg (1 PEN) SQ every OTHER week. <input type="checkbox"/> Inject 80mg (2 PENS) SQ on DAY 1 & DAY 2, then 80mg (2 PENS) SQ on DAY 15, and then 40mg (1 PEN) SQ every OTHER week.	
<input type="checkbox"/> <b>Humira 40mg PEN</b> <input type="checkbox"/> <b>Humira 40mg PFS</b> SIG: Inject 40mg SQ every OTHER week <input type="checkbox"/> Other: _____	
Qty: 1 MO SUPPLY	Refill x _____ Months
<b><u>Cimzia 200mg/mL Prefilled Syringe</u></b> <input type="checkbox"/> VIAL SIG: <input type="checkbox"/> Inject 400mg (2 PFS) SQ week 0, week 2, week 4, then every 4 weeks. <input type="checkbox"/> Inject 400mg (2 PFS) SQ every 4 weeks. <input type="checkbox"/> Other: _____	<b><u>Remicade 100mg Vial</u></b> (Dose: 5mg/kg) SIG: <input type="checkbox"/> Administer _____ mg IV on: week 0, week 2, week 6, then every 8 weeks. <input type="checkbox"/> Administer _____ mg IV every 8 weeks. <input type="checkbox"/> Other: _____ Qty: 1 MO SUPPLY    Refill x _____ Months

\*If you would like brand name, please write Medically Necessary.  
 Please note that Axium will dispense our formulary product unless otherwise specified.

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**IMPORTANT NOTICE:** This transmission may contain confidential health information that is legally protected. As you are obligated to maintain it in a safe and confidential manner, unauthorized re-disclosure or a failure to maintain the confidentiality of the information contained herein could subject you to penalties under state and federal law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination or copying of this communication is strictly prohibited.