UNIVERSAL
• SPECIALTY PHARMACY •

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www.rxuniversal.com

Gastroenterology A-H Referral Form

☐ **Urgent/Stat** ☐ **Standard**

Prescriber

Prescriber Information

Prescriber Name:			☐MD ☐PA ☐NP	
NPI:	DEA:		Office Contact:	
Address:				
City:	State:	Zip:	Phone #:	Fax #:

Patient

Patient Information - Fax A Copy Of The Front And Back Of All Insurance Cards

First Name:	MI:	Last Name:	
DOB:	Sex: ☐M ☐F	Last 4 Digits SSN :	Interpreter: ☐Y ☐N Specify:
Address:			
City:	State:	Zip:	Primary #:	Alternate #:
Emergency Contact:	Phone #:	Contact Preference:	☐AM ☐Noon ☐PM

Clinical

Clinical Information - Please Send Progress Notes, Lab Reports And Any Other Supporting Documents

ICD10/ Diagnosis Code:

Crohn's Disease: ☐K50.0 ___ (Crohn's of the **Small** intestine) ☐K50.1 ___ (Crohn's of the **Large** intestine) ☐K50.8 ___ (Crohn's of the **Both** intestine) ☐K50.9 ___ (Crohn's Unspecified)

Ulcerative Colitis: ☐K51.0 ___ (Ulcerative Pancolitis) ☐K51.2 ___ (Ulcerative Procolitis) ☐K51.3 ___ (Ulcerative Rectosigmoiditis) ☐K51.5 ___ (Left Sided Colitis) ☐K51.8 ___ (Other Ulcerative Colitis)

☐K51.9 ___ (Ulcerative Colitis Unspecified) ☐K58.0 ___ (Irritable Bowel Syndrome with Diarrhea) ☐Other

Date of Diagnosis: / /	Negative TB: ☐Yes ☐No	Date: / /	Weight: _____ ☐lb / ☐kg	Height: _____ ☐in / ☐cm
Previous Therapies:			Allergies:	

Prescription

Prescription Information

Dose Start Date: / / ☐ New Prescription ☐ Refill Prescription ☐ New to Therapy ☐ Restarting Therapy

Deliver to: ☐ Patient´s Home ☐ Prescriber´s Office ☐ Other

Drug		Directions & Quantity	Refills
☐ Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ INITIAL: Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) ☐ MAINTENANCE: Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2	
☐ Entyvio®	☐ Vials	☐ INITIAL: Infuse 300 mg IV over 30 minutes at Day 0, 14, and 42 (Quantity: 3) ☐ MAINTENANCE: Infuse 300 mg IV over 30 minutes every 8 weeks (Quantity: 1)	
☐ Humira® Citrate Free	☐ Adult Crohn´s Starter Kit Pre-filled Syringe 20 mg	☐ INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every other week starting on day 29 (Quantity: 3) ☐ MAINTENANCE: Inject 40 SQ every other week (Quantity: 2)	
	☐ Pediatric Crohn´s Starter Kit Pre-filled Syringe 20 mg Weight Required	☐ INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 15, then 20 mg every other week starting on day 29 (Quantity: 2) ☐ MAINTENANCE: Inject 20 mg SQ every other week (Quantity: 2) ***intended for weight 17kg/37 lbs to <40kg/88 lbs***	
	☐ Pediatric Crohn´s Starter Kit Pen Pre-filled Syringe Weight Required	☐ INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every other week starting on day 29 (Quantity: 3) ☐ MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2) ***intended for weight 240kg/88 lbs ***	
☐ Humira®	☐ Adult Crohn´s/UC Starter Kit Pen Pre-filled Syringe	☐ INITIAL: Inject 160 mg SQ on day 1, then 80 mg on day 15 (Quantity: 6) ☐ MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2)	
	☐ Pediatric Crohn´s Starter Kit Pre-filled Syringe 20 mg Weight Required	☐ INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 15, then 20 mg every other week starting on day 29 (Quantity: 3) ☐ MAINTENANCE: Inject 20 mg SQ every other week (Quantity: 2) ***intended for weight 17kg/37 lbs to <40kg/88 lbs***	
	☐ Pediatric Crohn´s Starter Kit Pen Pre-filled Syringe Weight Required	☐ INITIAL: Inject 160 mg SQ on day 1, 80 mg day 15, then 40 mg every other week starting on day 29 (Quantity: 6) ☐ MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2) ***intended for weight >40kg/88 lbs***	

☐ Dispense ancillary supplies, syringes and medical equipment necessary to administer medication.

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training ☐ Universal to coordinate injection training

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

Sign

Prescriber Signature and Date (Required to validate prescription)

Physician Signature:	Date: / /