PUBLIX PHARMACY

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Crohn's Disease/ Ulcerative Colitis Referral Form

Publix Specialty Pharmacy (#3212)

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Phone: 855-797-8254
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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ___________________________________ Patient's Last Name: ______________________________ Date of Birth: ___/___/_____ ☐ Male ☐ Female

Address: ____ City: _________________________ State: __________ Zip: ________________

Primary Phone Number: (_____) _________________________ Alt. Phone Number: (_____) _______________________ Caregiver name: _________________________

Clinical Information [Attach copy of labs and office notes]

Diagnosis code: _____________ Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other: ____

Treatment status: ☐ New to therapy, previously denied by insurance: ☐ No ☐ Yes, include copy of denial letter Weight: ______☐ kg ☐ lb

☐ Continuation of therapy, start date: ___/___/_____ Is the patient on samples? ☐ No ☐ Yes Height: ______☐ cm ☐ in

TB test results (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: ___/____/______ Allergies: ☐ NKDA ☐ Other: ________________________________

Systemic corticosteroids: ☐ Active, name and dose: ______________________________________ ☐ Contraindicated/failed, describe: __________________________

Aminosalicylates (e.g. sulfasalazine, mesalamine): ☐ Active, name and dose: __________________________ ☐ Contraindicated/failed, describe: __________________________

Immunomodulators (e.g. azathioprine, 6-MP, MTX): ☐ Active, name and dose: ________________________ ☐ Contraindicated/failed, describe: __________________________

Biologics (e.g. TNF blockers): ☐ Never tried ☐ Contraindicated/failed, describe: ____

Other pertinent past medical history and/or drug therapy: ____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY	REFILLS
☐ Cimzia (certolizumab pegol)	☐ Starter Kit: 200 mg/mL PFS	Initial Dose: Inject 400 mg (2 x 200 mg) SC on days 1, 15, and 29	3 doses	0
	☐ 200 mg/mL PFS ☐ 200 mg vial	Maintenance Dose: Inject 400 mg (2 x 200 mg) SC every 4 weeks	☐ 28 days ☐ 84 days	________
☐ Entyvio (vedolizumab)	☐ 300 mg vial	☐ Initial Dose: Infuse 300 mg IV over 30 minutes on days 1, 15, and 43	3 doses	0
		☐ Maintenance Dose: Infuse 300 mg IV over 30 minutes every 8 weeks	56 days	________
	Include: ☐ Sterile water for inj 5 mL vial ☐ Sodium chloride 0.9% inj 250 mL bag	Use 4.8 mL to reconstitute vedolizumab vial before dilution Dilute reconstituted vedolizumab into 250 mL of NS	QS	________
☐ Humira (adalimumab)	☐ Starter Kit: 6 x 40 mg pen ☐ 40 mg PFS	Initial Dose: ☐ Inject 160 mg (4 x 40 mg) SC on day 1, then 80 mg (2 x 40 mg) on day 15 ☐ Inject 80 mg (2 x 40 mg) SC on days 1, 2, and 15	28 days	0
	☐ 40 mg pen ☐ 40 mg PFS	Maintenance Dose (starting on day 29): Inject 40 mg SC every 2 weeks	☐ 28 days ☐ 84 days	________
☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda)	100 mg vial Patient weight: ________	Initial Dose: ☐ Infuse ______ mg (___ mg/kg) IV over at least 2 hours on days 1, 15, and 43	3 doses	0
		Maintenance Dose: ☐ Infuse ______ mg (___ mg/kg) IV over at least 2 hours every _____ weeks	1 dose	________
	Include: ☐ Sterile water for inj 10 mL vial ☐ Sodium chloride 0.9% inj 250 mL bag	Use 10 mL to reconstitute each 100 mg infliximab vial before dilution Dilute reconstituted infliximab to a final concentration of 0.4 to 4 mg/mL	QS	________
☐ Simponi (golimumab)	☐ 100 mg/0.5 mL SmartJect ☐ 100 mg/0.5 mL PFS	Initial Dose: ☐ Inject 200mg (2 x 100 mg) SC on day 1, then 100 mg on day 15	28 days	0
		Maintenance Dose: ☐ Inject 100 mg SC every 4 weeks	☐ 28 days ☐ 84 days	________
☐ Stelara (ustekinumab)	☐ 130 mg vial Patient weight: ________	Initial Dose: ☐ ≤ 55 kg: Infuse 260 mg IV over at least 1 hour on day 1 ☐ 56-85 kg: Infuse 390 mg IV over at least 1 hour on day 1 ☐ >85 kg: Infuse 520 mg IV over at least 1 hour on day 1	56 days	0
	Include: ☐ Sodium chloride 0.9% inj 250 mL bag	Dilute total volume of ustekinumab to a final volume of 250 mL	QS	________
	☐ 90 mg/ mL PFS	Maintenance Dose (starting on day 57): Inject 90 mg SC every 8 weeks	56 days	________

Prescriber Information [Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____] Use Cover My Meds: ☐ No ☐ Yes

Name: ____ DEA# ________________________ NPI # ______________________________________

Address: ____ City: __________________________ State: ___________ Zip: ____________________

Office Phone Number: (_______) ______________________ Fax Number: (_______) __________________________ Office Contact: ____________________________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

For states requiring hand written expressions to prevent substitution, write here:

Prescriber's signature:
(stamps not accepted)

______________________________________ ______________________________________
☐ Substitution allowed Date ☐ Dispense as written/ Do not substitute Date

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