SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
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Crohn's Disease/Ulcerative Colitis Referral Form

Patient Information

Date:_____ Patient SS#:_____ ☐ Male ☐ Female
Patient's First Name:_____ Patient's Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Best Phone #:_____ Alternate Phone #:_____
DOB:_____ Caregiver:_____ Allergies:_____
Drug Allergies:_____ ☐ No Known Drug Allergies

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Clinical

Prior history:
☐ 5-ASA
☐ Immunosuppressants (6-MP or other)
☐ Corticosteroids
☐ Methotrexate
☐ Surgery
☐ Other _____

Prior biologic use: **Date of last dose:**
☐ Remicade® _____
☐ Humira® _____
☐ Simponi® _____
☐ Cimzia® _____

Primary diagnosis (ICD-9-CM):
CD: ☐ 555.0 ☐ 555.1 ☐ 555.2 ☐ 555.9
UC: ☐ 556.5 ☐ 556.6 ☐ 556.8 ☐ 556.9
Date of Diagnosis:_____
Does patient have a Negative Tb test result ?
☐ YES ☐ NO
Date of Test: _____

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Cimzia®**	☐ Cimzia Starter Kit (Prefilled Syringes) ☐ 200 mg Lyophilized Vials (LYO)	**Induction Dose** ☐ 400 mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200 mg/mL PFS ☐ 3 Cartons = 6 x 200 mg Vials (LYO)	
	☐ 200 mg/mL Prefilled Syringes ☐ 200 mg Lyophilized Vials (LYO)	**Maintenance Dose** ☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200 mg/mL PFS ☐ 1 Carton = 2 x 200 mg Vials (LYO)	_____
☐ **Humira®**	☐ Humira Induction Dose ☐ **Pens** ☐ **Prefilled Syringes (PFS)**	**Induction Dose** ☐ 160 mg Sub-Q Day 1, 80 mg Day 15, 40 mg Day 29 and every other week thereafter	☐ 1 Kit = 6 x 40 mg **Pens** ☐ 3 Cartons = 6 x 40 mg **PFS**	
	☐ 20 mg Prefilled Syringe (peds) ☐ 40 mg Pens ☐ 40 mg Prefilled Syringes ☐ 50 mg/0.5 mL Prefilled Syringe	**Maintenance Dose** ☐ 40 mg Sub-Q every other week ☐ 40 mg Sub-Q once weekly	☐ 1 Carton = 2 x 40 mg **Pens** ☐ 1 Carton = 2 x 40 mg **PFS** ☐ 2 Cartons = 4 x 40 mg **Pens** ☐ 2 Cartons = 4 x 40 mg **PFS**	
	☐ 20 mg/0.4 mL Prefilled Syringe	☐ Inject 20mg Sub-Q every OTHER week		
☐ **Remicade®**	☐ 100 mg Vial (IV use only)	**Induction Dose** ☐ 5mg/kg IV at weeks 0, 2, and 6	_____ vial(s)	
	☐ 100 mg Vial (IV use only)	**Maintenance Dose** ☐ 5mg/kg IV every 8 weeks thereafter	_____ vial(s)	
☐ **Simponi®**	☐ 50 mg/0.5 mL SmartJect® Autoinjector ☐ 100 mg/1mL SmartJect® Autoinjector ☐ 100 mg/1mL Prefilled Syringe	**Induction Dose** ☐ 200 mg Sub-Q at Week 0, 100mg at Week 2 and every 4 weeks thereafter	☐ 3 x 100 mg SmartJect® Autoinjector ☐ 3 x 100 mg PFS	_____
		Maintenance Dose ☐ 100 mg Sub-Q every 4 weeks	☐ 1 x 100 mg SmartJect® Autoinjector ☐ 1 x 100 mg PFS	_____

Patient Support

Cimzia Injection Training/Nurse Support: **Physician Signature required for Injection Training**

Cimzia Prefilled Syringe (PFS)
☐ Office to train patient
☐ Home Health Nurse to train

Cimzia Lyophilized Powder (LYO)
☐ Office to administer
☐ Home Health Nurse to administer

Induct: ☐ All (OR) ☐ 1 (Week 0) ☐ 2 (Week 2) ☐ 3 (Week 4)
Maint: ☐ All

Humira Injection Training/Nurse Support: **Physician Signature required for Injection Training**
myHUMIRA Nurse (RN) visit to provide education & training for Sub-Q injection ☐ Patient's Home or Clinic Site ☐ Physician's Office ☐ No Nurse

Simponi Injection Training/Nurse Support: ☐ SimponiOne RN to provide education & training for Sub-Q injection ☐ No Nurse Training Needed

Patient Support: I authorize SPS Specialty Pharmacy Services to enroll me in the pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. I further authorize SPS to release and communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, contact me occasionally for market research purposes, and provide educational information regarding therapies and disease states. I understand I may revoke this authorization at anytime in writing by sending a letter to SPS Specialty Pharmacy Services, Plaza Notre Dame #5, 75 Ave. Luis Muñoz Marín Caguas, PR 00725. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original.

Patient Signature (required):_____ Date:_____

Prescriber Information

Date Shipment Needed:_____ Ship to: _____Patient _____Physician/Clinic
Ship to Other:_____
Physician Name (please print): _____ Contact Name: _____
Phone #:_____ Fax #: _____ NPI #: _____
Office Address:_____ City: _____ State: _____ Zip:_____

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature:_____ Date: _____