benevere PHARMACY

60 Market Center Dr. #103, Collierville, TN 38017

O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560

beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Inflammatory Bowel Disease Referral Form

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____

NPI# _____ Tax ID _____

Practice Name _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Phone _____ Fax _____

Office Contact _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

DOB _____ SSN _____

Drug Allergies _____ ☐ Male ☐ Female

Patient Weight: _____ Height: _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____ Secondary Insurance (if applicable) _____

Insurance Phone _____ Insurance Phone _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis: ☐ K50.9 Crohn's disease NOS ☐ K51.9 Ulcerative Colitis ☐ Other _____ TB/PPD Test Given? ☐ Yes ☐ No Date ____/____/____

Please indicate current or previous treatments and treatment duration below:

	Treatment	Dose I Duration			Treatment	Dose I Duration	
☐	Corticosteroids	_____	☐ Current Therapy ☐ Failed	☐	5-ASA	_____	☐ Current Therapy ☐ Failed
☐	Methotrexate	_____	☐ Current Therapy ☐ Failed	☐	6-MP	_____	☐ Current Therapy ☐ Failed
☐	Azathioprine	_____	☐ Current Therapy ☐ Failed	☐	Other	_____	☐ Current Therapy ☐ Failed
☐	Sulfasalazine	_____	☐ Current Therapy ☐ Failed				

Failed Biologic(s) & Duration of Each: _____

Other medications patient is currently taking including OTC medications with dosage and directions (or fax Rx profile) _____

Will patient stop taking above medications before starting the new medication? ☐ Yes ☐ No If YES, what is the washout period? _____

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Pharmacy to coordinate injection training

DRUG NAME		PRESCRIPTION ORDERS *(PLEASE CHECK ONE OR MORE)*	QUANTITY	REFILLS
☐ Cimzia® Prefilled Syringe		☐ **Initial** dose of 400mg under the skin at weeks 0, 2, and 4, then maintenance dosing (below) ☐ **Maintenance:** dose of 400mg under the skin every 4 weeks	1 Starter Kit 28 Day Supply	0
☐ Entyvio® 300mg vial		☐ **Induction:** infuse 300mg intravenously at weeks 0 and 2. Begin maintenance at week 6 ☐ **Maintenance:** infuse 300mg intravenously every 8 weeks	2 1	0
☐ Humira® – Citrate Free		☐ **Induction:** inject 160mg under the skin on day 1, then 80mg on day 15, maintenance dose on Day 29. ☐ **Maintenance:** 40mg (1pen) under the skin every other week [OR] ☐ Other _____	1 Starter Kit 28 Day Supply 28	0
☐ Simponi® 100mg/ml	☐ SmartJect™ ☐ Prefilled syringe	☐ **Induction:** inject 200mg on Day 1, then 100mg on Day 15, then maintenance dose ☐ **Maintenance:** inject 100mg under the skin every 4 weeks ☐ Other _____	3 28 Day Supply	0
☐ Remicade® 100mg vial		Directions:	28 Day Supply	
☐ Stelara®	☐ 130mg Vial ☐ 90mg Prefilled	☐ **Induction:** Initial dose_____ mg intravenously ☐ **Maintenance:** Inject 90mg subcutaneously every 8 weeks starting 8 weeks after infusion	56 Day Supply 56 Day Supply	0
☐ Xeljanz®	☐ 5mg ☐ 10mg	Take 1 tablet by mouth twice daily	30 Day Supply	
Other medications		Directions:		

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____