Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS
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Crohn's Disease/Ulcerative Colitis/GI Referral Form

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location):_____ Date Needed:_____ ❑Need Nurse ❑Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	
Sex: ❑ Male ❑Female **Weight** lbs/kg Height	
Allergies:	

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis
❑K50. _____ Crohn's Disease ❑K51. _____ Ulcerative Colitis
❑Other_____
Date of Diagnosis:_____
Complications present: ❑Rectal bleeding ❑Obstruction ❑ Fistulas ❑Abscess ❑Other_____
Severity of disease: ❑Mild ❑Moderate ❑Severe
TB/PPD test given? ❑Yes ❑No Date:_____ Results?_____
Hepatitis B infection ruled out? ❑Yes ❑No
Weight loss >10%? ❑Yes ❑No Anemia? ❑Yes ❑No
Abdominal mass? ❑Yes ❑No Fever? ❑Yes ❑No
Overall abdominal pain: ❑None ❑Mild ❑Moderate ❑Severe
Does patient have serious/active infection? ❑Yes ❑No
Has patient been diagnosed with heart failure? ❑Yes ❑No
Has patient been diagnosed with lymphoma? ❑Yes ❑No
Presence of autoantibody formation/lupus-like syndrome? ❑Yes ❑No

Prior and Current Treatment *(please attach list if necessary)*
Is the patient currently being treated or previously been treated for diagnosis indicated? ❑Yes ❑No
If yes, name the product(s), approximate date range(s) and response/outcome, listing current therapy first if applicable.
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Does patient have any contraindications or intolerances to any medications? ❑Yes ❑No
If yes, please name medication and describe contraindication or reaction? _____
Concomitant medications:_____
Will patient be discontinuing any current medication(s) before starting new medication? ❑Yes ❑No
Labs: *please include copy of most recent lab work results*
ALT:_____Date:_____ AST:_____Date:_____
Hgb _____Date:_____ Platelet:_____Date:_____
Albumin_____Date:_____Serum creatinine:_____ Date:_____
Pregnancy (if appropriate):_____ Date:_____

PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
Cimzia® *(Crohn's)*	❑ Starter Kit 200mg PFS ❑ 200mg/mL PFS	Initial ❑ Inject 400mg SC at weeks 0, 2, & 4 Maintenance: ❑ Inject 200mg SC every other week **OR** ❑ Inject 400mg SC every 4 weeks	❑ 6 x 200mg/mL ❑ 2 x 200mg/mL	0 _____
Humira® *(Crohn's/UC)*	❑ Crohn's/UC Starter Pack **CF** ❑ Crohn's/UC Starter Pack ❑ 40mg/0.4mL Pen **CF** ❑ 40mg/0.4mL PFS **CF** ❑ 40mg/0.8mL Pen ❑ 40mg/0.8mL PFS	Loading: ❑ Inject 160mg SC for first dose (Day 1). Then inject 80mg SC two weeks after first dose (Day 15). Maintenance: ❑ Inject 40mg SC on day 29 and every other week thereafter.	❑ 3 x 80mg/0.8mL **CF** Pens ❑ 6 x 40mg/0.8mL Pens ❑ 2 injections	0 _____
Simponi® *(UC)*	❑ 100mg/mL PFS ❑ 100mg/mL SmartJect® Autoinjector	Induction ❑ Inject 200mg SC at week 0, then inject 100mg SC at week 2 Maintenance ❑ Inject 100mg SC every 4 weeks	❑ 3 x 100mg/mL ❑ 1 x 100mg/mL	0 _____
Stelara® *(Crohn's)*	❑ 90mg/mL PFS	❑ Inject 90mg SC 8 week s following initial IV dose, then every 8 weeks thereafter Date of last infusion:_____	❑ 1 x 90mg/mL	_____
Xeljanz® *(UC)*	❑ 10mg tablet ❑ 10mg tablet ❑ 5mg tablet	❑ Take 1 tablet by mouth twice daily for 8 weeks ❑ Take 1 tablet by mouth twice daily	❑ 60 tablets ❑ 60 tablets	1 _____
Other	❑ _____	❑ _____	❑ _____	

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

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.*

Date: _____

_____ **DISPENSE AS WRITTEN**

_____ **MAY SUBSTITUTE**