BARNEY'S SPECIALTY PHARMACY
2604 PEACH ORCHARD RD.
AUGUSTA, GA, 30906
706-849-4161 (PHONE)
762-585-9793 (FAX)

Crohns/UC Referral Form

Patient Demographics: **Please attach a copy of patient's insurance card (front and back)**

First Name:	**Last Name:**	**Date of Birth:** M ☐ F ☐
Address:	**City:**	**State:** **Zip:**
Phone:	**Social Security #:**	**Allergies:**

Diagnosis and Clinical Information: **(Attach clinical notes, lab work, and prior medication history)**

Diagnosis(ICD-10):_____
Date of Diagnosis:_____
Negative Tb/PPD test?: ☐ Yes ☐ No
Date of Tb/PPD test:_____
Is Patient currently on medication: ☐Yes ☐No
Current med: _____

Prior Medications:
Medication:_____Date(s):_____
Medication:_____Date(s):_____
Medication:_____Date(s):_____
Reason(s) for Discontinuation:_____
_____

Prescription Information:

Drug	Strength	Directions	Quantity	Refills
Cimzia	☐ Cimzia Starter Kit	☐ **Induction Dose:** Inject 400mg SubQ every 2 weeks for 3 doses, then maintenance dose	☐ 1 kit	0
	☐ 200mg/ml prefilled syringe	☐ **Maintenance Dose:** Inject 400mg SubQ every 4 weeks	☐ 1 box (2 syringes)	
Humira	☐ Crohn's Starter Pack 80mg/0.8ml **(Citrate-Free)** ☐ Crohn's Starter Pack 40mg/0.4ml	☐ **Induction Dose:** Inject 160mg SubQ on day 1, then 80mg SubQ on day 15, then maintenance dose starting on day 29	☐ 1 kit	0
	☐ 40mg/0.4ml pen **(Citrate-Free)** ☐ 40mg/0.8ml pen ☐ 40mg/0.4ml prefilled syringe **(Citrate-Free)** ☐ 40mg/0.8ml prefilled syringe	☐ **Maintenance Dose:** Inject 40mg SubQ every other week ☐ **Other:**_____	☐ 1 kit (2 doses)	
Simponi	☐ 100mg/1ml prefilled syringe ☐ 100mg/1ml Autoinjector	☐ **Induction Dose:** Inject 200mg at week 0, then 100mg at week 2, followed by maintenance dose starting at week 6	☐ 3 doses	0
		☐ **Maintenance dose:** Inject 100mg SubQ every 4 weeks	☐ 1 dose	
Stelara	☐ 90mg/ml prefilled syringe	*(Maintenance dosing begins 8 weeks after IV induction dose.)* ☐ **Maintenance dose:** Inject 90mg SubQ every 8 weeks	☐ 1 syringe	
Other				

Preferences:

Delivery Option: ☐ MD Office ☐ First Fill to Office, then Patient Home ☐ Patient
Patient Injection Training: ☐ MD Office ☐ Barney's Pharmacy ☐ Alternate Program

Prescriber Information:

Name:		**NPI:**	**DEA:**
Address:		**City:**	**State:** **Zip:**
Phone:	**Fax:**	**Specialty:**	**Office Contact:**

Updated April 2020

Prescriber Signature:_____**Date:**_____

By signing this form and utilizing our services, you are authorizing Barney's Specialty Pharmacy to serve as your designated prior authorization agent in dealing with third party payors. Pharmacy is also authorized to investigate patient insurance benefits and will also explore financial assistance for patient via pharmaceutical manufacturer programs and patient assistance foundations.