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: 400mg SC at weeks 0, 2, & 4, then maintenance Maintenance: ❑ 200mg SC every other week OR ❑ 400mg SC every 4 weeks	1 Kit= 6 x 200mg/mL PFS 1 Carton= 2 x 200mg/mL PFS	
Humira® *(Crohn's/UC)*	❑ Starter Pack (Pens) ❑ 40mg/0.8mL Pen ❑ 40mg/0.8mL PFS	❑ Induction: Inject 160mg (four 40mg pens) SC for first dose (Day 1). Then inject 80mg (two 40mg pens) SC two weeks after first dose (Day 15). Then inject 40mg SC every other week starting at week 4 (Day 29) as maintenance dose. Maintenance: ❑ 40mg SC every OTHER week	1 Starter kit= 6 x 40mg/0.8mL Pens 1 carton=2 x 40mg/0.8mL	
Simponi® *(UC)*	❑ 100mg/mL PFS ❑ 100mg/mL SmartJect® Autoinjector	❑ Induction: Inject 200mg (two 100mg doses) SC at week 0, then inject 100mg SC at week 2, followed by maintenance therapy of 100mg every 4 weeks starting at week 6. ❑ Maintenance: Inject 100mg SC every 4 weeks.	3 boxes=3 x 100mg/mL (for induction) 1 box=1 x 100mg/mL	
Xifixan®	❑ 550mg tablets	❑ For IBS-D: Take 1 tablet by mouth three times daily for 14 days.	42 tablets	
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 payors, processors and other entities.*

Prescriber's Signature: _____ Date:_____