



Patient Referral/ Medication Request Crohn's Disease

Aetna Specialty Pharmacy®
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Today's Date: _____

Anticipated Start Date: _____

PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office			Email Address:

INSURANCE INFORMATION

Primary Insurance:		Pharmacy Benefit Manager (PBM):	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:
Secondary Insurance:			
Policy #:	Group #:	Insured:	Phone:

PHYSICIAN INFORMATION

First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:			Email Address:		Phone:

DIAGNOSIS:

Primary:	ICD 9:	Secondary:	ICD 9:
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PRESCRIPTION (Please select from below and provide approximate days supply.)

<p>CIMZIA # of Refills _____</p> <p><input type="checkbox"/> Cimzia 200mg single dose vials 2/bx qty _____ bxs</p> <p><input type="checkbox"/> Cimzia 200mg single use prefilled syringes 2/bx qty _____ bxs</p> <p>Directions: <input type="checkbox"/> Initial dose: 400mg SQ at week 0, week 2, and week 4 <input type="checkbox"/> Maintenance dose: 400mg SQ every 4 weeks</p>	<p>HUMIRA # of Refills _____</p> <p><input type="checkbox"/> Humira Pen Crohn's Disease Starter Pkg; 40 mg/pen; 6/box</p> <p><input type="checkbox"/> Humira 40mg single use Pen; 2/bx qty _____ bxs</p> <p><input type="checkbox"/> Humira 40mg single use prefilled syringes; 2/bx qty _____ bxs</p> <p><input type="checkbox"/> Humira 20mg single use prefilled syringes; 2/bx qty _____ bxs</p> <p>Directions: <input type="checkbox"/> 160mg (4 pens) SQ as initial dose, followed by 80mg (2 pens) SQ on day 15, then 40mg (1 pen) SQ every other week thereafter</p> <p><u>Or</u></p> <p><input type="checkbox"/> 80mg (2 pens) SQ daily x 2 days as initial dose, followed by 80mg (2 pens) SQ on day 15, then 40mg (1 pen) SQ every other week thereafter</p> <p>Maintenance dose:</p> <p><input type="checkbox"/> 40mg SQ every 2 weeks</p> <p><input type="checkbox"/> 40mg SQ every week</p> <p>Other: _____</p>
<p>REMICADE # of Refills _____</p> <p>Patient's Current Weight: _____ lbs/kg (required) Dose per kg _____</p> <p>One per infusion:</p> <p><input type="checkbox"/> Remicade single use 100mg vials qty _____ vials</p> <p><input type="checkbox"/> Excel Sodium Chloride; 250ml bag qty _____ bags</p> <p><input type="checkbox"/> Sterile water for injection; 10ml/vial qty _____ vials</p> <p><input type="checkbox"/> Normal saline flush; 10mL/PFS qty _____ syringes</p> <p><input type="checkbox"/> Epipen® <input type="checkbox"/> Benadryl® 50mg vial PRN allergic reaction</p> <p>Directions: _____</p>	<p>TYSABRI : THIS IS FOR INFORMATIONAL PURPOSES ONLY. TYSABRI IS AVAILABLE ONLY UNDER A SPECIAL RESTRICTED DISTRIBUTION PROGRAM CALLED CD TOUCH. PLEASE CONTACT THE TOUCH PRESCRIBING PROGRAM AT 1-800-456-2255.</p>
<p>Other Drug: _____ strength _____</p> <p>Frequency _____ Route _____</p> <p># of Refills _____</p> <p>Directions: _____</p>	

Prescriber's Signature Required by Law: _____ **Date:** ____ / ____ / ____

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.
Incomplete information may result in therapy delay. Please complete all fields.