Crohn's Disease
REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Considerations
Diagnosis (ICD 10) : □ K50 Crohn's disease of small intestine without complications □ Other (please specify)_____ □ Previously Tried/Failed Therapies_____

Drug Name	Strength/Directions for use	Quantity	Refills
□ **Humira®**	□ 40mg SC every 2 weeks □ Start: 160mg SC x 1 on week 0, then 80mg SC x 1 on week 1, the 40mg SC every 2 weeks □ 80mg SC x 3 doses on days 1,2 & 15, then 40mg SC every 2 weeks starting on day 28 □ Other		
□ **Cimzia ®**	□ 400mg SC every 4 weeks □: Start 400mg SC x1 on weeks 0,2,4 □ Other: _____		
□ **Remicade®**	□ Dose: □ Weight:		
□ **Entyvio ®**	□ 300mg infused intravenously over 30 minutes at 0, 2, 6 weeks, then every 8 weeks thereafter.		

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this □ DAW___ **Date**