MedicoRx Specialty
& HOME INFUSION PHARMACY

Ulcerative Colitis
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) : □ K51 Ulcerative Colitis □ Other (please specify)_______________________________________

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		
□ **Simponi®**	□ Induction: Inject 200gm SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 □ Maintenance: 100mg SC every 4 weeks starting at week 6, following induction dose □ Other:		
□ **Remicade®**	□ Dose: □ Weight:		
□ **Uceris®**	□ 9mg tablet once daily by mouth		
□ **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**