Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to pharmacy.

Inflammatory Bowel Disease

Referral for Medication and Patient Management Program

OptiMed

Phone: 877.385.0535
Fax: 877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

Patient Demographics

Name _____ Sex ☐M ☐F
DOB _____ SSN _____
Phone _____ 2nd Phone _____
Address _____ Apt/Suite _____
City, State, ZIP _____
Primary language, if other than English _____

Provider Information

Prescriber _____
NPI _____ DEA _____
Practice Name _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____ Key contact _____

This is a ☐ New Rx ☐ Refill

Training by ☐ Prescriber's office ☐ Pharmacy to facilitate ☐ Not needed

Ship first fill to ☐ Prescriber's office ☐ Patient ☐ Other _____

Clinical Information

Diagnosis

Crohn's Disease
☐ K50.0 Crohn's Disease (Small Intestine)
☐ K50.1 Crohn's Disease (Large Intestine)
☐ K50.8 Crohn's Disease (Both Intestines)
☐ K50.9 Crohn's Disease, unspecified
☐ Other _____

Ulcerative Colitis
☐ K51.0 Ulcerative Pancolitis
☐ K51.2 Ulcerative Proctitis
☐ K51.3 Ulcerative Rectosigmoiditis
☐ K51.5 Left Sided Colitis
☐ K51.8 Other Ulcerative Colitis
☐ K51.9 Ulcerative Colitis, Unspecified
☐ Other _____

Date of negative TB test _____ or Check here if ☐ TB test pending, will fax results
HBV negative or treated ☐ Yes ☐ No
Weight _____ ☐ lb ☐ kg **Height** _____ ☐ in
Allergies _____
Prior treatment, treatment dates, and reason for discontinuation _____
Comorbid conditions _____
Other notes _____

Medication	Directions	Quantity	Refills
☐ **Cimzia®** 200mg (certolizumab)	☐ **Initial:** Inject 400mg (2 syringes) SQ at weeks 0, 2, and 4. **Maintenance:** ☐ Beginning week 6, inject 200mg (1 syringe) SQ every OTHER week. ☐ Beginning week 8, inject 400mg (2 syringes) SQ every 4 weeks. ☐ Other _____	6 syringes ☐ 2 syringes ☐ Other _____	Zero _____
☐ **Humira®** 40mg ^ (adalimumab)	☐ **Initial:** Inject 160mg SQ on day 0, 80mg on day 14, then 40mg every OTHER week thereafter. ☐ **Maintenance:** Inject 40mg SQ every OTHER week. ☐ Other _____	1 starter package (28-day supply) 2 pens/syringes ☐ Other _____	Zero _____
^Citrate-free (CF) Humira will be dispensed unless unavailable or otherwise specified.			
To order **INFLIXIMAB** IV infusion products such as **Remicade®**, **Inflectra®**, or **Renflexis®**, please locate the **INFLIXIMAB Infusion** referral form at https://www.optimedhealthpartners.com/referrals			
☐ **Simponi®** (golimumab)	☐ **Initial:** Inject 200mg SQ week 0, 100mg week 2, then 100mg every 4 weeks thereafter. ☐ **Maintenance:** Beginning week 6, inject 100mg SQ every 4 weeks. ☐ Other _____	3 pens/syringes 1 pen/syringe ☐ Other _____	Zero _____
☐ **Stelara®** (ustekinumab)	**Initial:** To order **Stelara® initial IV infusion dose** please locate the drug-specific referral form at https://www.optimedhealthpartners.com/referrals ☐ **Maintenance:** Inject 90mg SQ every 8 weeks, beginning 8 weeks after initial IV dose. ☐ Other _____	1 dose ☐ Other _____	_____
Site of Care: OptiMed Infusion Center or home infusion nurse to administer Stelara SQ. Alternatively, the patient may be trained to self-administer as appropriate.			
☐ **Xeljanz®** ☐ **Xeljanz XR®** (tofacitinib)	#**REQUIRED:** ANC_____ Lymph_____ Hgb_____ Date_____ **Initial:** ☐ Take 10mg PO twice daily for 8 weeks. ^ ☐ Take 22mg PO once daily for 8 weeks. ^ Do not crush, split, or chew. **Maintenance:** ☐ Take 5mg PO twice daily. ☐ Take 11mg PO once daily. Do not crush, split, or chew. **Dose adjustment*:** ☐ _____	☐ 60 tablets 30 tablets 60 tablets 30 tablets ☐ Other _____	 1 Refill _____
^Begin with Xeljanz 10mg PO twice daily or Xeljanz XR 22mg once daily for at least 8 weeks, then evaluate for therapeutic response. If needed continue for a maximum of 16 weeks. *For patients with mod-to-severe renal impairment, moderate hepatic impairment, or strong CYP450 drug interactions, use half the total daily dose. Not recommended with severe hepatic impairment. #**REQUIRED:** Notate or attach a copy of the patient's current CBC and CMP with LFTs. These labs and lipids should be assessed at baseline and reassessed at the recommended intervals.			
☐ Other Medication Drug _____	☐ _____	☐ _____	

Please note: To increase adherence and patient acceptance all medications will be dispensed as pen type injectors unless unavailable or otherwise specified.

Provider Signature _____ **Date** _____

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

V03022020A

CLEAR FORM