AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

STARTER DOSE PAGE 1

GASTROENTEROLOGY HUMIRA BIOSIMILAR REFERRAL FORM

MAINTENANCE DOSE PAGE 2

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description) ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Crohn's Disease ☐ K51.9 Ulcerative Colitis ☐ Other: _____

- Has patient been treated *previously* for this condition? ☐ Yes ☐ No Is patient *currently* on therapy? ☐ Yes ☐ No Please list medication(s) and treatment duration: _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No If *yes*, how long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
- Has patient received a **Quatiferon gold**, **Tspot** or **PPD (tuberculosis) Skin Test**? ☐ Yes ☐ No Date: _____ Results: ☐ Negative ☐ Positive

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** **Copay ID:**

PRESCRIPTION INFORMATION

Humira® CF ☐ **Starter Package 80 mg/0.8 mL Pen** *NDC: 0074-0124-03* ☐ Starter Dose Not Needed ☐ **Enroll in Humira Complete Program**
☐ *Starter Dose:* Two 80 mg SQ inj. **Day 1**, one 80 mg SQ inj. **Day 15** QTY: 3 Pens | Refills: 0
☐ *Starter Dose:* One 80 mg SQ inj. **Day 1**, one 80 mg SQ inj. **Day 2**, one 80 mg SQ inj. **Day 15** QTY: 3 Pens | Refills: 0

Humira® CF ☐ **40 mg/0.4 mL Pen** *NDC: 0074-0554-02* *OR* ☐ **40 mg/0.4 mL Prefilled Syringe** *NDC: 0074-0243-02*
☐ *Maintenance Dose:* One 40 mg SQ inj. **Day 29** & every other week thereafter QTY: 2 | Refills:
☐ *Alternate Dose:* _____ QTY: | Refills:

Starter Dose *(please make a selection)* ☐ **No Starter Dose Needed -** *Select here if patient only needs maintenance dose*

Abrilada™ *(adalimumab – afzb)*	**Amjevita®** *(adalimumab-atto)*	**Cyltezo®** *(adalimumab-adbm)*	**Hadlima®** *(adalimumab-bwwd)*	**Hulio®** *(adalimumab-fkjp)*
☐ 40 mg/0.8 mL PFS	☐ 40 mg/0.8 mL PFS	☐ 40 mg/0.8 mL PFS	☐ 40 mg/0.8 mL PFS	☐ 40 mg/0.8 mL PFS
☐ 40 mg/0.8 mL ***Pen***	☐ 40 mg/0.8 mL ***Pen***	☐ 40 mg/0.8 mL ***Pen***	☐ 40 mg/0.8 mL ***Pen***	☐ 40 mg/0.8 mL ***Pen***
	☐ 40 mg/0.4 mL PFS	☐ 40 mg/0.4 mL PFS	☐ 40 mg/0.4 mL PFS	
	☐ 40 mg/0.4 mL ***Pen***	☐ 40 mg/0.4 mL ***Pen***	☐ 40 mg/ 0.4 mL ***Pen***	
	☐ 80 mg/0.8 mL ***Pen***	☐ 40 mg/0.8 mL x 6 ***Pen*** CD/UC/HS Starter Kit		

Hyrimoz® *(adalimumab-adaz)*	**Idacio®** *(adalimumab-aacf)*	**Simlandi®** *(adalimumab-ryvk)*	**Yuflyma®** *(adalimumab-aaty)*	**Yusimry®** *(adalimumab-aqvh)*
☐ 40 mg/0.4 mL PFS	☐ 40 mg/0.8 mL PFS	☐ 40 mg/0.4 mL PFS	☐ 40 mg/0.4 mL PFS	☐ 40 mg/0.8 mL ***Pen***
☐ 40 mg/0.4 mL ***Pen***	☐ 40 mg/0.8 mL ***Pen***	☐ 40 mg/0.4 mL ***Pen***	☐ 40 mg/0.4 mL ***Pen***	
☐ 80 mg/0.8 mL ***Pen***	☐ 40 mg/0.8 mL x 6 ***Pen*** CD/UC Starter Kit		☐ 80 mg/0.8 mL ***Pen***	
☐ 80 mg/0.8 mL x 3 ***Pen*** CD/UC Starter Kit			☐ 80 mg/0.8 mL x 3 ***Pen*** CD/UC/HS Starter Kit	
☐ 80 mg/0.8 mL x 3 PFS CD Starter Kit *(PEDS)*				
☐ 80 mg/0.8 mL x 1 and 40 mg/0.4 mL x 1 PFS CD Starter Kit *(PEDS)*				

Directions ***(please select one)***	**QUANTITY**	**REFILLS**
☐ Inj 160 mg SQ Day 1, then 80 mg SQ Day 15	28 DAY SUPPLY	0
☐ (for CD, PEDS ≥ 6 yo, 17 kg to < 40 kg) Inj 80 mg SQ Day 1, then 40 mg SQ Day 15 DO NOT SELECT this PEDS Starter Dosing with Hadlima, Idacio, Simlandi, Yuflyma or Yusimry (due to no 20 mg dosing available for Maintenance)	28 DAY SUPPLY	0
☐ Other:		0

Please select Maintenance Dose below ***(see page 2)***

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description) ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Crohn's Disease ☐ K51.9 Ulcerative Colitis ☐ Other: _____

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- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No If *yes*, how long should patient wait before starting the new medication?
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
- Has patient received a **Quatiferon gold**, **Tspot** or **PPD (tuberculosis) Skin Test**? ☐ Yes ☐ No Date: _____ Results: ☐ Negative ☐ Positive

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

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PRESCRIPTION INFORMATION

Maintenance Dose *(please make a selection)*

Abrilada™ *(adalimumab – afzb)* ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL ***Pen***	**Amjevita®** *(adalimumab-atto)* ☐ 20 mg/0.2 mL PFS ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL ***Pen*** ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL ***Pen***	**Cyltezo®** *(adalimumab-adbm)* ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL ***Pen*** ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL ***Pen***	**Hadlima®** *(adalimumab-bwwd)* ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL ***Pen*** ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL ***Pen***	**Hulio®** *(adalimumab-fkjp)* ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL ***Pen***
Hyrimoz® *(adalimumab-adaz)* ☐ 20 mg/0.2 mL PFS ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL ***Pen***	**Idacio®** *(adalimumab-aacf)* ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL ***Pen***	**Simlandi®** *(adalimumab-ryvk)* ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL ***Pen***	**Yuflyma®** *(adalimumab-aaty)* ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL ***Pen***	**Yusimry®** *(adalimumab-aqvh)* ☐ 40 mg/0.8 mL ***Pen***

Directions *(please select one)*	QUANTITY	REFILLS
☐ Inj 40 mg SQ every other week	28 DAY SUPPLY	
☐ (for CD, PEDS 17 kg to <40 kg) Inj 20 mg SQ every other week	28 DAY SUPPLY	
☐ Other:		

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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