AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

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

CROHN'S DISEASE PEDIATRIC REFERRAL FORM

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 ☐ 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

EpiPen® ☐ **0.3 mg** IM x 1, may repeat QTY: 2 | Refills:

EpiPen® JR ☐ **0.15 mg** IM x 1, may repeat QTY: 2 | Refills:

Hyrimoz® Pediatric Crohn's Starter Package CF *(Ages 6 - 17)*

☐ **17 kg to < 40 kg:** one 80 mg / 0.8 mL and one 40 mg / 0.4 mL *NDC: 0074-0124-03* QTY: _____ | Refills:
Inj. SQ 80 mg on **Day 1** (1 Syringe); then 40 mg on **Day 15** (1 Syringe); then Maintenance Dosing

☐ **≥ 40 kg:** three 80 mg / 0.8 mL Prefilled Syringes QTY: _____ | Refills:
Inj. SQ 160 mg on **Day 1** (2 Syringes on Day 1); then 80 mg on **Day 15** (1 Syringe); then Maintenance Dosing

Hyrimoz® Pediatric Crohn's Maintenance Dose CF *(Ages 6 - 17)*

☐ **17 kg to < 40 kg:** 20 mg / 0.2 mL Prefilled Syringe QTY: _____ | Refills:
Inj. SQ 20 mg on **Day 29**; then every other week

☐ **≥ 40 kg:** 40 mg / 0.4 mL Prefilled Syringe *NDC: 0074-0243-02* QTY: _____ | Refills:
Inj. SQ 40 mg on **Day 29**; then every other week

☐ **≥ 40 kg:** 40 mg / 0.4 mL Prefilled Injectable Pen *NDC: 0074-0554-02* QTY: _____ | Refills:
Inj. SQ 40 mg on **Day 29**; then every other week

☐ **Other:** _____ QTY: _____ | Refills:

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.