ACS Advanced Care Scripts

Biologic Therapy Referral Form

Phone: 877-985-MEDS (6337) **Fax: 866-679-7131**

First Name:	*Middle Initial:*	*Last Name:*	
Date of Birth:	*Gender:* ☐ M ☐ F	*SSN:*	
Street Address:	City:	State:	Zip Code:
Home Phone:	*Work Phone:*	*Cell Phone:*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card

Insurance Carrier Name - Primary:	*Name of Insured:*	*Relationship:*
ID#:	*Group #:*	*Insurance Phone:*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription

Drug Name	Form/Strength/Directions for Use	Qty	Refills
Xifaxan	☐200mg ☐550mg ____mg po ☐BID ☐TID for _____ days		
Simponi	☐ Initial Dosing: 200mg SC week 0 then 100mg SC week 2 | ☐ Other: ___ ☐ Ongoing treatment: 100mg SC every 4 weeks ☐ Other: ___		
Cimzia (200mg vials or PFS)	☐ lyophilized vial | ☐ Pre-filled syringe ☐ Initial dosing: 400mg SC at 0, 2, 4 weeks then ☐ Ongoing treatment: 400 mg SC every 4 weeks		
Stelara	**Starting Dose:** ☐ 45mg PFS SC x1 followed by 45mg PFS SC in 4 weeks (For patients weighting ≤ 100kg) ☐ 90 mg PFS SC x1 followed by 90mg PFS SC in 4 weeks (For patients weighting > 100kg) **Maintenance dosing:** ☐ 45mg PFS SC every 12 weeks , ☐ 90mg PFS SC every 12 weeks ☐ 260mg ☐ 390mg ☐ 520mg followed by ☐ 90mg IV every 8 weeks		
Humira (supplied as 40mg pens or PFS) Humira Pediatric (supplied as PFS)	☐ Initial dosing: Crohn's /Ulcerative Colitis Starter Pack-six 40mg single dose pens 160mg (four 40mg injections) SC x one dose (day 1) then 80mg SC x one two weeks later (day 15) ☐ Ongoing treatment: ☐ Pen or ☐ PFS 40mg SC every other week (Start 29 days after initial dosing) | Other: **Initial dosing for children >/= 6 and >/= 40kg:** ☐ 4x40mg inj SC on Day 1 then 2x40mg inj SC 2 weeks later on Day 15 (tray of 6) ☐ 2x40mg inj SC on Days 1 & 2 then 2x40mg inj SC 2 weeks later on Day 15 (tray of 6) **Initial dosing for children >/= 6 and weighing 17kg to < 40kg:** ☐ 2x40mg inj SC on Day 1 then 1x40mg SC 2 weeks later on Day 15 (tray of 3) **Maintenance:** ☐ 40mg SC every other week ☐ 20mg SC every other week		
Relistor	☐150mg tab ☐8mg/0.4ml Sol'n for Inj ☐ 12mg/0.6ml Sol'n for Inj Sig: _____		
Other			

Information Needed to Obtain Prior Authorizations

Primary Diagnosis: ☐ ICD-10 | ☐ Other: ___	
Weight: pounds	*Allergies:* ___
Failed Therapies: ___	*Please provide current list of medications:* ___

Complete Prescriber Information in Section Below NOT Included on Attached Prescription

MD First Name:		*MD Last Name:*		*DEA #:*
UPIN:	*State License #:*	*NPI:*	*Office E-mail:*	
Office Address:		City:	State:	Zip Code:
Office Phone:		*Office Fax:*	*Office Contact Name:*	

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Advanced Care Scripts to initiate a Prior Authorization on my behalf.*	**DATE** *TLC 1/24/17*
Dr: ***Substitution Permitted***	**Dr:** ***No Substitution Permitted***