Padek Healthcare
Quality Care From The Pharmacists You Trust
PHARMACY

Padek Healthcare Crohn's & Ulcerative Colits Referral Form

5403 A Annapolis Rd Bladensburg, MD 20710
Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

Diagnosis: Crohn's Disease ☐ K50.00 ☐ K50.10 ☐ K50.80 ☐ K50.90 Ulcerative Colitis ☐ K51.20 ☐ K51.80 ☐ K51.90

TB/PPD Test given? ☐ Yes ☐ No Chest X-Ray ☐ Yes ☐ No Results _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRIOR | CURRENT TREATMENTS

☐ Azathioprine ☐ Corticosteroids
☐ 5-ASA ☐ 6-MP ☐ NSAIDS
☐ Methotrexate ☐ Sulfasalazine
☐ Other _____
Dose | Duration _____

SIMPONI® (golimumab) ☐ SmartJect™ ☐ Prefilled Syringe

☐ **STARTER** 200mg SC at week 0, then 100mg SC at week 2 **QTY:** 3 (100 mg/mL)
☐ **MAINTENANCE**
100mg SC every 4 weeks **QTY:** 1 (100 mg/mL)
50mg SC every 4 weeks **QTY:** 1 (50 mg/0.5mL)
☐ Other _____ Refill X _____

HUMIRA

☐ **STARTER** Day 1: Inject 160mg (4 pens) SQ.
Day 15: Inject 80mg (2 pens) SQ.
Day 29: maintenance
☐ **MAINTENANCE** Inject (1 Pen) 40mg/0.8ml every other week
☐ Other _____
QUANTITY 4 week supply Refill X _____

CIMZIA

☐ **STARTER** 400mg SQ initially and at week 2 & 4
☐ **MAINTENANCE** 400 mg SQ every 4 weeks
QUANTITY 4 week supply Refill X _____

REMICADE 100 mg vial

☐ MD Office Infusion
Infusion supplies needed ☐ YES ☐ NO
☐ **STARTING DOSE:**
5 mg/kg ____mg on week 0, week 2 & week 6 then,
☐ **MAINTENANCE DOSE:**
5 mg/kg _____ mg every 8 weeks for ____ infusions every 8 weeks
☐ Other _____
QTY _____ Refills _____

By signing this form and utilizing our services, you are authorizing Padek Healthcare and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

PLEASE FAX COMPLETED REFERRAL FORM TO PADEK HEALTHCARE AT 301-277-7127