Crohn's / GI / UC Prescription Referral Form

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

AssureRx PHARMACY
2026 Babcock Road, Suite # 104 • San Antonio- 78229, TX
Ph : 210.467.5174 • Fax: 210.467.5184 • www.AssureRxPharmacy.com

Date Medication Needed: _____ **Ship To:** ◯ Patient's Home ◯ Prescriber's Office ◯ Pick-up _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** Male Female **Height:** _____ **Weight:** _____ lbs. kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** _____ **Fax:** _____

City, State, Zip: _____ **Key Contact:** _____ **Phone:** _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: _____ **ICD-10:** _____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Cimzia®	Prefilled Syringes (2x200mg) (or) Lyophilized vials (2 x 200mg)	**Induction Dose:** Inject 400mg SC at weeks 0, 2, and 4 **Maintenance Dose:** 400mg SC every 4 weeks	_____	_____
Humira® Injection training from My Humira ***(patient must sign below)***	20mg Pen 20mg Prefilled Syringe 40mg Pen 40mg Prefilled Syringe Starter Pack	**Induction Dose:** Inject 160mg SC (four 40mg Pens) for first Dose (Day 1). Then Inject 80mg SC (two 40mg Pen) two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29) **Maintenance Dose:** Inject 40mg SC (one 40mg Pen) every other week	_____ _____	 _____
Xifaxan®	200mg tabs 550mg tabs	Take tablets times per day		
Remicade®	100mg vial			
Simponi®	100mg SmartJect® 100mg Pre-filled Syringe	**Induction Dose:** Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 **Maintenance Dose:** 100mg SC every 4 weeks starting at week 6, after Induction dose	3 1	 _____
Entyvio®	300mg vial			

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____