

# Inflammatory bowel disease—oral

Four simple steps to submit your referral.

## 1 PATIENT INFORMATION

New patient  Current

Patient's name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
 Street address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parent/guardian (if applicable) \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
 Evening phone \_\_\_\_\_ E-mail address \_\_\_\_\_  
 Patient's primary language:  English  Other If other, please specify \_\_\_\_\_

Please attach front and back of patient's insurance cards or complete information below.

Insurance company \_\_\_\_\_ Phone \_\_\_\_\_  
 Insured's name \_\_\_\_\_  
 Insured's employer \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
 Prescription card:  Yes  No If yes, carrier \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Is patient eligible for Medicare?  Yes  No  
 Does patient have a secondary insurance?  Yes  No

## 2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_  
 Prescriber's name and title \_\_\_\_\_  
 If NP or PA, under direction of Dr. \_\_\_\_\_  
 Office contact and title \_\_\_\_\_  
 Clinic/hospital affiliation \_\_\_\_\_  
 Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_ License # \_\_\_\_\_

## 3 CLINICAL INFORMATION

Primary ICD-10 code: \_\_\_\_\_  
 Rationale for therapy \_\_\_\_\_  
 Current weight \_\_\_\_\_ kg/lbs Date recorded \_\_\_\_\_  
 Height \_\_\_\_\_ in/cm BSA \_\_\_\_\_ m<sup>2</sup>  
 NKDA  Known drug allergies \_\_\_\_\_  
 Concurrent meds \_\_\_\_\_

## 4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Xeljanz® (tofacitinib citrate)	<input type="checkbox"/> 5 mg tablets <input type="checkbox"/> 10 mg tablets	<input type="checkbox"/> Take 10 mg by mouth twice daily for 8 weeks, followed by 5 mg twice daily <input type="checkbox"/> Take 10 mg by mouth twice daily <input type="checkbox"/> Take 5 mg by mouth twice daily <input type="checkbox"/> Take 5 mg by mouth once daily <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____

By signing below, I certify that the above therapy is medically necessary.  
 Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date \_\_\_\_\_ Substitution allowed \_\_\_\_\_ Date \_\_\_\_\_ Dispense as written \_\_\_\_\_

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the Crohn's team at 866.489.1901.  
 To reach your team, call toll-free 866.489.1899.