



CEDRA

CROHN'S DISEASE/GASTRO

REFERRAL FORM

FAX: 888.889.7129

TOLL FREE: 844.233.7279

CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: DOB: Preferred Phone:
SSN#: Language: English Other
Address: Sex: Male Female Height: Weight: lbs kg
City: State: Zip: Known Allergies:

* PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING *

PRESCRIBER INFORMATION

Prescriber Name: DEA#: NPI#: Tax ID#:
Address: Phone: E-mail:
City: State: Zip: Key Contact: Phone: Fax:
STATUS UPDATE PREFERENCE: Phone Text Fax E-mail:

DIAGNOSIS/CLINICAL INFORMATION

ICD-10 Code:
History: Has the patient been treated previously for this condition? Yes No
NSAIDS Duration Sulfasalazine Duration Corticosteroid Duration
MTX Duration 5-ASA (5-Aminosalicylates) Duration 6-MP (6-Mercaptopurine) Duration
Biologics Duration Azathioprine Duration Other Duration
Is the patient currently on any therapy? Yes No List Meds:
Will patient stop taking meds before starting the new med? Yes No
How long will the patient wait before starting the new med?
Other meds patient is on?
What type of TB test did patient receive: PDD QFT-G Results:
Gallbladder removal?* Yes No Hepatic impairment?* Yes No Child-Pugh class:*

*Pertains only to VIBERZI™ prescriptions

PRESCRIPTION INFORMATION

Table with 5 columns: MEDICATION, DOSE/STRENGTH, SIG, QTY., REFILLS. Rows include CIMZIA, DIFACID, ENTYVIO, HUMIRA, REMICADE, SIMPONI, STELARA, VIBERZI, and XIFAXAN.

Date Medication Needed: Deliver To: Patient Home MD Office

Prescriber Signature: (Please sign and date below)
Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible Date Dispense as written "DAW" Date

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