



(Christus SantaRosa Hospital, Tower # 1)

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

Crohn's / GI / UC Prescription Referral Form

2829 Babcock Road, Suite # 120 • San Antonio- 78229, TX • Ph : 210.617.4311 • Fax: 210.617.4312
www.GalaxySpecialtyPharmacy.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® <i>Injection training from My Humira (patient must sign below)</i>	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 Permissible _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. 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: _____