Pediatric Gastroenterology

Fax Referral To: 877-438-9380

ContinuumRx Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

Need By Date: _____ Ship To: ☐Patient ☐Office ☐Other _____ Fax Copy: ☐Rx Card Front/Back ☐Clinical Notes ☐Medical Card Front/Back

Patient Information

Patient Name ☐ Male ☐Female	
Address	
City State Zip	
Main Phone	Alternate Phone
Social Security #	Date of Birth
Parent/Guardian Name	

Prescriber Information

Prescriber Name		
Address		
City State Zip		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐K50.90 Pediatric Crohn's Disease ☐K51.90 Pediatric Ulcerative Colitis ☐K20.0 Eosinophilic Esophagitis
☐ Other: _____ Dx Code: _____

Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____ _____ Length of Treatment: _____ Reason for Discontinuing: _____ _____ Length of Treatment: _____ Reason for Discontinuing: _____

Drug Allergies	Latex Allergy: ☐No ☐Yes
Weight ☐ kg ☐lbs	TB Test: ☐No ☐Yes Date: _____ Results: _____ (please send lab results)

Prescription Information

			Qty	Refills
☐ Dupixent® **12+ years old, ≥40kg*	300mg ☐Pen ☐PFS w/Shield	Inject 300mg subcutaneously every week	4 Syringes	_____
☐ Humira® Citrate Free Crohn's	**17kg to <40kg**			
	☐ Pediatric Crohn's Disease Starter Package (2 count) 80mg/0.8mL, 40mg/0.4mL in a single-use PFS	Load: Inject 80mg subcutaneously on day 1, then inject 40mg two weeks later on day 15, then inject 20mg every other week starting on day 29	Loading Dose	None
	☐ 20mg PFS	Maintenance: Inject 20mg subcutaneously every other week	4 Week Supply	_____
	≥40kg			
	☐Pediatric Crohn's Disease Starter Package (3 count) 80mg/0.8mL in a single-use PFS 40mg ☐PFS ☐Pen	Load: Inject 160mg subcutaneously as ☐two-80mg injections on day 1 **or** ☐ 80mg on day 1 and then day 2, then inject 80mg two weeks later on day 15, then inject 40mg every other week starting on day 29	Loading Dose	None
		Maintenance: Inject 40mg subcutaneously every other week	4 Week Supply	_____
☐ Humira® Citrate Free UC	**20kg to <40kg**			
	☐ 40mg Pen	Load: Inject 80mg subcutaneously on day 1, then inject 40mg on day 8 and day 15, then inject maintenance dose starting on day 29	Loading Dose (4 pens)	None
	☐ 20mg PFS	Maintenance: Inject 20mg subcutaneously every week	4 Week Supply	_____
	☐ 40mg Pen	Maintenance: Inject 40mg subcutaneously every other week	4 Week Supply	_____
	≥40kg			
	☐ Pediatric UC Disease Starter Package (4 count) 80mg/0.8mL in a single-use pen	Load: Inject 160mg subcutaneously as ☐two-80mg injections on day 1 **or** ☐ 80mg on day 1 and then day 2, then inject 80mg on day 8 and day 15, then inject maintenance dose starting on day 29	Loading Dose	None
	☐ 40mg Pen	Maintenance: Inject 40mg subcutaneously every week Maintenance:	4 Week Supply	_____
	☐ 80mg Pen	Inject 80mg subcutaneously every other week	4 Week Supply	_____
☐ Remicade®	100mg Vial	☐ Load: Infuse _____ mg (5mg/kg) at 0, 2, and 6 weeks, then every 8 weeks thereafter	Loading Dose	None
		☐ Maintenance: Infuse _____ mg (5mg/kg) every 8 weeks	8 Week Supply	_____
☐ Other				

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW) By signing this form and utilizing our services, I am also authorizing **ContinuumRX** to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ Prescriber's Signature (no stamps) Substitution Permitted _____ Date

_____ Prescriber's Signature (no stamps) Dispense As Written _____ Date

Legal Notice: The prescriber is to comply with their 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. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.