

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Alternate Phone: _____
 Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS/CLINICAL INFORMATION

K50.00 Crohn's Disease
 K51.90 Ulcerative Colitis
 Other: _____

Prior Medication Failed: _____
 Length of Treatment: _____
 Reason for Discontinuation: _____

TB/PPD test: Positive Negative Date Read: _____
 Patient Weight: _____ kg lbs Height: _____ cm in
 Allergies: _____
 Lab Data: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200mg X2 PFS	<input type="checkbox"/> Inject 400mg SC at weeks 0, 2, and 4 <input type="checkbox"/> Inject 400mg once monthly <input type="checkbox"/> Inject 200mg every other week	1 month supply	
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300mg/ml vial	<input type="checkbox"/> Initial: Infuse 300mg over 30 minutes at weeks 0, 2 and 6 <input type="checkbox"/> Maintenance: Infuse 300mg over 30 minutes every 8 weeks	1 month supply	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 40mg SC once a week <input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Inject 160mg SC day 1, 80mg day 15, then 40mg every other week (per Humira starter kit)	1 month supply	
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Inject _____ mg at weeks 0, 2, and 6 <input type="checkbox"/> Inject _____ mg every _____ weeks		
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100mg Pen			
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 130mg/26ml vial <input type="checkbox"/> 90mg PFS <input type="checkbox"/> 250mL NaCl bag	<input type="checkbox"/> Up to 55kg, infuse 260mg (2 vials) as a single IV infusion <input type="checkbox"/> Greater than 55kg to 85kg, infuse 390mg (3 vials) as a single IV infusion <input type="checkbox"/> Greater than 85kg, infuse 520mg (4 vials) as a single IV infusion <input type="checkbox"/> Inject 90mg SC every 8 weeks		
<input type="checkbox"/> Other:				

ADDITIONAL COMMENTS:

Prescriber Signature: _____ Date: _____ UPIN: _____

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