

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: Patient MD Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____ Gender: _____
 Emergency Contact: _____ Phone: _____

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:

PATIENT 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: _____
 Weight: _____ kg lbs Height: _____ cm in %BSA: _____
 Allergies: _____ NKDA
 Injection Training/Home Health RN visit is necessary: Yes No
 Site of Care: Home MD Office Other: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Refills:
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200 mg prefilled syringe <input type="checkbox"/> 200 mg vial	<input type="checkbox"/> INITIAL: Inject 400 mg (two 200 mg injections) SUBQ on day 0, 14, and 28 (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 400 mg (two 200 mg injections) SUBQ every 4 weeks (Quantity: 2)	
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300 mg vial	<input type="checkbox"/> INITIAL: Infuse 300 mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Infuse 300 mg IV over 30 minutes every _____ weeks (Quantity: 1)	
<input type="checkbox"/> Humira® <input type="checkbox"/> Humira® Citrate Free	<input type="checkbox"/> Crohn's/UC Starter Package <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg prefilled syringe	<input type="checkbox"/> INITIAL: Inject 160 mg SUBQ on day 1, then 80 mg day 15, then maint. dose (1 pkg) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SUBQ every other week (Quantity: 2)	
<input type="checkbox"/> Inflectra®		<input type="checkbox"/> INITIAL: Infuse IV _____ mg per kg (Dose _____ mg) at 0, 2, and 6 weeks (Quantity: _____) <input type="checkbox"/> MAINTENANCE: Infuse IV _____ mg per kg (Dose _____ mg) every _____ weeks (Quantity: _____)	
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100 mg vial	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Pharmacist will round to the nearest 100 <input type="checkbox"/> Give exact dose (do NOT round)	
<input type="checkbox"/> Renflexis™			
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg SmartJect® Pen <input type="checkbox"/> 100 mg prefilled syringe	<input type="checkbox"/> INITIAL: Inject 200 mg SUBQ on day 0, then 100 mg on day 14 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 100 mg SUBQ every 4 weeks (Quantity: 1)	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 130 mg (26mL vials) <input type="checkbox"/> 90 mg (2x 45 mg vials)	<input type="checkbox"/> INITIAL: Weight based dosing, infuse IV up to 55 kg = 260 mg (2 vials), > 55 kg to 85 kg = 390 mg (3 vials), > 85 kg = 520 mg (4 vials) <input type="checkbox"/> MAINTENANCE: Inject 90 mg SUBQ 8 weeks after initial dose, then every 8 weeks thereafter	
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 10 mg tablets <input type="checkbox"/> _____ mg tablets	<input type="checkbox"/> INITIAL: Take 10 mg PO twice daily (Quantity: 60 with 1 refill) <input type="checkbox"/> MAINTENANCE: Take _____ mg PO twice daily (Quantity: 60)	
<input type="checkbox"/> Other:			

Premedications & Other Medications:

▶ Infusion supplies as per protocol
 ▶ Anaphylaxis Kit as per protocol

Acetaminophen: _____ mg PO prior to infusion
 Diphenhydramine: _____ mg PO IV
 250ml 0.9% NaCl for hydration
 Other: _____

Flush Protocol:

▶ NaCl 0.9% 10ml
 ▶ Before and after infusion

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____