

✂ 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:
Cimzia®	200 mg prefilled syringe 200 mg vial	Initial: Inject 400 mg (two 200 mg injections) SUBQ on day 0, 14, and 28 (Quantity: 6) Maintenance: Inject 400 mg (two 200 mg injections) SUBQ every 4 weeks (Quantity: 2)	
Entyvio®	300 mg vial	Initial: Infuse 300 mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3) Maintenance: Infuse 300 mg IV over 30 minutes every _____ weeks (Quantity: 1)	
Humira® Humira® Citrate Free	Crohn's/UC Starter Package 40 mg Pen 40 mg prefilled syringe	Initial: Inject 160 mg SUBQ on day 1, then 80 mg day 15, then maint. dose (1 pkg) Maintenance: Inject 40 mg SUBQ every other week (Quantity: 2)	
Avsola®	100 mg vial	Initial: Infuse IV _____ mg per kg (Dose _____ mg) at 0, 2, and 6 weeks (Quantity: _____) Maintenance: Infuse IV _____ mg per kg (Dose _____ mg) every _____ weeks (Quantity: _____) Other: _____	
Inflectra®			
Inflectra®			
Renflexis™		Pharmacist will round to the nearest 100 Give exact dose (do NOT round)	
Simponi®	100 mg SmartJect® Pen 100 mg prefilled syringe	Initial: Inject 200 mg SUBQ on day 0, then 100 mg on day 14 (Quantity: 3) Maintenance: Inject 100 mg SUBQ every 4 weeks (Quantity: 1)	
Skyrizi IV®	600mg/10mL vial	Initial: 600mg administered by IV over at least one hour at week 0, week 4, and week 8 (Quantity: 3) **Induction Dosing Only	
Stelara®	130 mg (26mL vials) 90 mg (2x 45 mg vials)	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) Maintenance: Inject 90 mg SUBQ 8 weeks after initial dose, then every 8 weeks thereafter	
Xeljanz®	10 mg tablets _____ mg tablets	Initial: Take 10 mg PO twice daily (Quantity: 60 with 1 refill) Maintenance: Take _____ mg PO twice daily (Quantity: 60)	
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:** _____