

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

Date Required: _____		Ship To: ☐ Patient ☐ MD Office ☐ Other: _____	
PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name: _____		Prescriber Name: _____	
Address: _____		Address: _____	
City, State, Zip: _____		City, State, Zip: _____	
Home Phone: _____		Phone: _____	
Cell Phone: _____		Fax: _____	
Date of Birth: _____ Gender: _____		DEA #: _____ NPI #: _____	
Emergency Contact: _____ Phone: _____		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: _____			
TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: _____ HBV: ☐ Positive ☐ Negative ☐ NA ☐ 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:
☐ Entyvio®	☐ 300mg vial	☐ Initial: Infuse 300mg IV over 30 minutes at week 0, week 2, and week 6 (Quantity: 3) ☐ Maintenance: Infuse 300mg IV over 30 minutes every _____ weeks (Quantity: 1)	
☐ Avsola® ☐ Inflectra® ☐ Remicade® ☐ Renflexis®	☐ 100mg 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: _____ ☐ Pharmacist will round to the nearest 100 ☐ Give exact dose (do NOT round)	
☐ Omvoh®	☐ 300 mg/15 mL vial	☐ Ulcerative Colitis: Infuse 300mg IV over at least 30 minutes at week 0, week 4, and week 8 (Quantity 3) ***Induction dosing only. ☐ Crohn's Disease: Infuse 900mg IV over at least 90 minutes at week 0, week 4, and week 8 (Quantity 3) ***Induction dosing only.	
☐ Skyrizi®	☐ 600mg/10mL vial ☐ 600mg/10mL vial x 2 ☐ 180mg/1.2mL On-Body Injector KIT ☐ 360mg/2.4mL On-Body Injector KIT	☐ Crohn's Initial: 600mg administered by IV over at least one hour at week 0, week 4, and week 8 (Quantity: 3) ☐ Ulcerative Colitis Initial: 1200mg administered by IV over at least two hours at week 0, week 4, and week 8 (Quantity: 3) ☐ Maintenance: ☐ 180mg or ☐ 360mg SUBQ at week 12 and every 8 weeks thereafter.	
☐ Stelara®	☐ 130mg (26mL vials) ☐ 90mg (2x 45mg vials)	☐ Initial: Weight based dosing, infuse IV up to 55kg = 260mg (2 vials), > 55kg to 85kg = 390mg (3 vials), > 85kg = 520mg (4 vials) ☐ Maintenance: Inject 90mg SUBQ 8 weeks after initial dose, then every 8 weeks thereafter	
☐ Tremfya®	☐ 200mg/20mL vial IV Induction ☐ 200mg/2ml x 2 Pen SUBQ Induction Pack ☐ 100mg/mL SUBQ ☐ 200mg/2mL SUBQ	☐ IV Induction: 200mg IV over at least 60 minutes at week 0, week 4, and week 8. ☐ SUBQ Induction: 400mg SUBQ (given as two consecutive injections of 200mg each) at week 0, 4, and 8. ☐ Maintenance: Inject 100mg SUBQ at week 16 and every 8 weeks thereafter. ☐ Maintenance: Inject 200mg SUBQ at week 12, and every 4 weeks thereafter.	
☐ Other:			
Premedications & Other Medications: ▶ Infusion supplies as per protocol ▶ Anaphylaxis Kit as per protocol ☐ Acetaminophen: _____ mg PO prior to infusion ☐ Diphenhydramine: _____ mg _____ PO _____ IV prior to infusion. ☐ 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:** _____

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