

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE - FIRST DOSE OFFICE - ALL DOSES OTHER _____

PATIENT INFORMATION		
Patient Name		
Address		
City	State	Zip
Main Phone	Alternative Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #		Date of Birth

PRESCRIBER INFORMATION		
Prescriber Name		
Prescriber Type	<input type="checkbox"/> Physician (MD or DO)	<input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant
Supervising Physician (If prescriber is a NP or PA)		
DEA #	NPI #	Tax ID #
Address		
City	State	Zip
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

CLINICAL INFORMATION			
Diagnosis: <input type="checkbox"/> K50.90 Crohn's Disease <input type="checkbox"/> K51.90 Ulcerative Colitis <input type="checkbox"/> Other:		DX Code:	
Patient Allergies		Weight	Height
Hepatitis Test Result	TB/PPD Test <input type="checkbox"/> Yes <input type="checkbox"/> No	Test Date	Test Results
Current Medications			
Prior Failed Medications	DURATION	DURATION	DURATION
<input type="checkbox"/> Corticosteroids:		<input type="checkbox"/> Remicade:	<input type="checkbox"/> Sulfasalazine:
<input type="checkbox"/> Azathioprine:		<input type="checkbox"/> Purinethol / 6-MP:	<input type="checkbox"/> Other:
<input type="checkbox"/> Methotrexate:		<input type="checkbox"/> 5-ASA (Mesalamine):	<input type="checkbox"/> Other:

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200x2 Prefilled Syringe <input type="checkbox"/> 200x2 LYO Powder	<input type="checkbox"/> INITIAL: Inject 400mg SQ at weeks 0, 2 and 4 <input type="checkbox"/> MAINTENANCE: Inject 400mg SQ once every 4 weeks or <input type="checkbox"/> Other:	1 Starter Kit 4 Week Supply	_____
<input type="checkbox"/> Entyvio™	300mg Vials	<input type="checkbox"/> INITIAL: Infuse 300mg intravenously over 30 minutes at day 0, day 14 and day 42 <input type="checkbox"/> MAINTENANCE: Infuse 300mg intravenously over 30 minutes every 8 weeks	3 Vials 1 Vial	_____
<input type="checkbox"/> Humira® Citrate Free	<input type="checkbox"/> Crohn's/ UC Starter Pack <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, then 80 mg on day 15 <input type="checkbox"/> MAINTENANCE: Inject 40mg SQ every other week	3 2	_____
<input type="checkbox"/> Humira®	<input type="checkbox"/> Crohn's/ UC Starter Pack <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, then 80 mg on day 15 <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week	6 2	_____
<input type="checkbox"/> Remicade®	Vials	<input type="checkbox"/> INITIAL: Infuse _____ mg on day 0, day 14 and day 42 <input type="checkbox"/> MAINTENANCE: Infuse _____ mg every 8 weeks	_____ _____	_____
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100mg SmartJect <input type="checkbox"/> 100mg Prefilled Syringe	<input type="checkbox"/> INITIAL: Inject 200mg SQ at week 0, then 100mg on week 2 <input type="checkbox"/> MAINTENANCE: Inject 100mg SQ every 4 weeks <input type="checkbox"/> OTHER:	Loading Dose 4 Week Supply	_____
<input type="checkbox"/> Stelara®	130mg Vials by Weight <input type="checkbox"/> Up to 55 kg <input type="checkbox"/> Greater than 55 kg to 85 kg <input type="checkbox"/> Greater than 85 kg <input type="checkbox"/> 90mg Prefilled Syringe	<input type="checkbox"/> INITIAL: Infuse 260mg (2 vials) intravenously X 1 at week 0 <input type="checkbox"/> INITIAL: Infuse 390mg (3 vials) intravenously X 1 at week 0 <input type="checkbox"/> INITIAL: Infuse 520mg (4 vials) intravenously X 1 at week 0 <input type="checkbox"/> MAINTENANCE, ALL WEIGHTS: Inject 90mg SQ 8 weeks after initial intravenous dose, then every 8 weeks thereafter	2 Vials 3 Vials 4 Vials 1 Syringe	_____
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 10mg Tablets <input type="checkbox"/> 5mg Tablets	<input type="checkbox"/> INITIAL: Take 10 mg by mouth twice daily <input type="checkbox"/> MAINTENANCE: Take 5 mg by mouth twice daily <input type="checkbox"/> MAINTENANCE: Take 10 mg by mouth twice daily	60	_____
<input type="checkbox"/> Other:	_____	_____	4 Week Supply	_____

Dispense As Written (no stamps)

Date

Substitution Permitted (no stamps)

Date

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.