

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

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Patient Name			Prescriber Name		
Address			Prescriber Type <input type="checkbox"/> Physician (MD or DO) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant		
City			Supervising Physician (If prescriber is a NP or PA)		
State			DEA #		
Zip			NPI #		
Main Phone			Tax ID #		
Alternative Phone			Address		
<input type="checkbox"/> Male <input type="checkbox"/> Female			City		
Social Security #			State		
Date of Birth			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"/> <b>INITIAL:</b> Inject 400mg SQ at weeks 0, 2 and 4 <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 400mg SQ once every 4 weeks or <input type="checkbox"/> Other:	1 Starter Kit 4 Week Supply	_____
<input type="checkbox"/> Dificid	200mg Tablet	Take 1 tablet by mouth twice a day		_____
<input type="checkbox"/> Entyvio™	300mg Vials	<input type="checkbox"/> <b>INITIAL:</b> Infuse 300mg intravenously over 30 minutes at day 0, day 14 and day 42 <input type="checkbox"/> <b>MAINTENANCE:</b> 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"/> <b>INITIAL:</b> Inject 160 mg SQ on day 1, then 80 mg on day 15 <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 40mg SQ every <b>other</b> week	3 2	_____
<input type="checkbox"/> Remicade® <input type="checkbox"/> Inflectra	Vials	<input type="checkbox"/> <b>INITIAL:</b> Infuse _____ mg on day 0, day 14 and day 42 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse _____ mg every 8 weeks	_____	_____
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100mg SmartJect <input type="checkbox"/> 100mg Prefilled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 200mg SQ at week 0, then 100mg on week 2 <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 100mg SQ every 4 weeks <input type="checkbox"/> <b>OTHER:</b>	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"/> <b>INITIAL:</b> Infuse 260mg (2 vials) intravenously X 1 at week 0 <input type="checkbox"/> <b>INITIAL:</b> Infuse 390mg (3 vials) intravenously X 1 at week 0 <input type="checkbox"/> <b>INITIAL:</b> Infuse 520mg (4 vials) intravenously X 1 at week 0 <input type="checkbox"/> <b>MAINTENANCE, ALL WEIGHTS:</b> 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"/> <b>INITIAL:</b> Take 10 mg by mouth twice daily <input type="checkbox"/> <b>MAINTENANCE:</b> Take 5 mg by mouth twice daily <input type="checkbox"/> <b>MAINTENANCE:</b> Take 10 mg by mouth twice daily	60	_____
<input type="checkbox"/> Xifaxan	550mg Tablet	Take 1 tablet by mouth three times a day		_____
<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 copy 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.