Gastroenterology

Avita
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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	❑ Male ❑ Female
Social Security #		Date of Birth

PRESCRIBER INFORMATION

Prescriber Name		
Prescriber Type	❑ Physician (MD or DO) ❑ Nurse Practitioner	❑ 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: ❑ K50.90 Crohn's Disease ❑ K51.90 Ulcerative Colitis ❑ K20.0 Eosinophilic Esophagitis ❑ Other:		DX Code:
Patient Allergies	Weight	Height
Hepatitis Test Result	TB/PPD Test ❑ Yes ❑ No Test Date	Test Results
Current Medications		

Prior Failed Medications *DURATION*	*DURATION*	*DURATION*
❑ Corticosteroids:	❑ Remicade:	❑ Sulfasalazine:
❑ Azathioprine:	❑ Purinethol / 6-MP:	❑ Other:
❑ Methotrexate:	❑ 5-ASA (Mesalamine):	❑ Other:

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PATIENT INFORMATION

Patient Name	Date of Birth	Prescription Date

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Cimzia®	❑ 200x2 Prefilled Syringe ❑ 200x2 LYO Powder	❑ **INITIAL:** Inject 400mg SQ at weeks 0, 2 and 4 ❑ **MAINTENANCE:** Inject 400mg SQ once every 4 weeks or ❑ Other:	1 Starter Kit 4 Week Supply	_____
❑ Dificid	200mg Tablet	Take 1 tablet by mouth twice a day	4 Week Supply	_____
❑ Dupixent	❑ 300mg/2ml Prefilled Syringe ❑ 300mg/2ml Pen	Inject 300mg subcutaneously once weekly	4 Week Supply	_____
❑ Entyvio™	300mg Vials	❑ **INITIAL:** Infuse 300mg intravenously over 30 minutes at day 0, day 14 and day 42 ❑ **MAINTENANCE:** Infuse 300mg intravenously over 30 minutes every 8 weeks	3 Vials 1 Vial	_____
❑ **Humira®** ***Citrate Free***	❑ Crohn's/ UC Starter Pack ❑ Pen ❑ Prefilled Syringe	❑ **INITIAL:** Inject 160 mg SQ on day 1, then 80 mg on day 15 ❑ **MAINTENANCE:** Inject 40mg SQ every **other** week	3 2	_____
❑ Remicade® ❑ Inflectra	Vials	❑ **INITIAL:** Infuse _____ mg on day 0, day 14 and day 42 ❑ **MAINTENANCE:** Infuse _____ mg every 8 weeks	_____ _____	_____
❑ Simponi®	❑ 100mg SmartJect ❑ 100mg Prefilled Syringe	❑ **INITIAL:** Inject 200mg SQ at week 0, then 100mg on week 2 ❑ **MAINTENANCE:** Inject 100mg SQ every 4 weeks ❑ **OTHER:**	Loading Dose 4 Week Supply	_____
❑ Stelara®	130mg Vials *by Weight* ❑ Up to 55 kg ❑ Greater than 55 kg to 85 kg ❑ Greater than 85 kg ❑ 90mg Prefilled Syringe	❑ **INITIAL:** Infuse 260mg (2 vials) intravenously X 1 at week 0 ❑ **INITIAL:** Infuse 390mg (3 vials) intravenously X 1 at week 0 ❑ **INITIAL:** Infuse 520mg (4 vials) intravenously X 1 at week 0 ❑ **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	_____
❑ Xeljanz	❑ 10mg Tablets ❑ 5mg Tablets	❑ **INITIAL:** Take 10 mg by mouth twice daily ❑ **MAINTENANCE:** Take 5 mg by mouth twice daily ❑ **MAINTENANCE:** Take 10 mg by mouth twice daily	60	_____
❑ Xifaxan	550mg Tablet	Take 1 tablet by mouth three times a day		_____
❑ 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.