

<p align="center"><u>PATIENT INFORMATION</u></p> <p>(Complete the following or send patient demographic sheet.) Please fax copy of patient's insurance card including both sides</p> <p>Name: _____ DOB: _____ Gender: M / F Height: _____ Wt: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Alternate Phone: _____ Last 4 digits SS#: _____ Email: _____</p>	<p align="center"><u>PRESCRIBER INFORMATION</u></p> <p>Prescriber Name: _____ State Lic. #: _____ NPI: _____ Facility Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Contact: _____ Phone: _____ Email: _____</p>
---	--

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

K50.90 Crohn's disease NOS K51.90 Ulcerative Colitis K20.00 Eosinophilic Esophagitis Other: _____

Please indicate current or previous treatments and treatment duration below:

<input type="checkbox"/> NSAIDS Duration: _____	<input type="checkbox"/> Corticosteroids Duration: _____
<input type="checkbox"/> Methotrexate Duration: _____	<input type="checkbox"/> Azathioprine Duration: _____
<input type="checkbox"/> Sulfasalazine Duration: _____	<input type="checkbox"/> 5 – ASA Duration: _____
<input type="checkbox"/> 6 – MP Duration: _____	<input type="checkbox"/> Other: Duration: _____

Other medications patient is currently taking: _____
 TB/PPD Test given? Yes No Date: _____ Results: _____ Allergies: _____
 BSA: _____
 Expected date of first/next dose: _____ Date of last dose: _____

PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
Cimzia® <input type="checkbox"/> Starter Kit <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Lyophilized Powder	<input type="checkbox"/> Initial dose: Inject 400 mg SC at week 0, week 2, and week 4	1 starter kit	0
	<input type="checkbox"/> Maintenance dose: Inject 400 mg SC every 4 weeks	28 day supply	
Dupixent® <input type="checkbox"/> 300mg/2mL Prefilled Pen <input type="checkbox"/> 300mg/2mL Prefilled Syringe	Adults: <input type="checkbox"/> 600 mg (two 300 mg injections) followed by 300 mg Q2W	28 day supply	
Entyvio® <input type="checkbox"/> 300 mg vial	<input type="checkbox"/> Initial Dose: Infuse 300mg IV over 30 minutes at week 0, week 2 and week 6 <input type="checkbox"/> Maintenance dose: Infuse 300mg IV over 30 minutes every 8 weeks	Initial dose QS	
Humira® Citrate Free <input type="checkbox"/> Crohn's/UC Starter Kit <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg PFS	<input type="checkbox"/> Initial Dose: Inject 160 mg SC on day 1, 80 mg on day 15, then 40 mg thereafter beginning on day 29	1 starter kit	0
	<input type="checkbox"/> Maintenance: Inject 40 mg SC every other week <input type="checkbox"/> Inject 40 mg SC once a week	28 day supply	
Humira® Citrate Free Pediatric <input type="checkbox"/> Pediatric Crohn's Starter <input type="checkbox"/> 20mg PFS <input type="checkbox"/> Pediatric UC Starter	<input type="checkbox"/> Initial Dose: Weight 17-39kg: Inject 80 mg SC on day 1, 40 mg on day 15, then 20 mg thereafter beginning on day 29	1 starter kit	0
	<input type="checkbox"/> Maintenance: Inject 20 mg SC every other week	28 day supply	
	<input type="checkbox"/> Initial Dose: Weight 20-39kg Inject 80 mg SC on day 1, 40 mg on day 8, then 40 mg on day 15 <input type="checkbox"/> Initial Dose: Weight >40kg Inject 160 mg SC on day 1, 80 mg on day 8, then 80 mg on day 15	1 starter kit	0
	<input type="checkbox"/> Maintenance: Weight 20-39kg Inject 40 mg SC every other week beginning on day 29 Inject 20 mg SC every week beginning on day 29 <input type="checkbox"/> Maintenance: Weight >40kg Inject 80 mg SC every other week beginning on day 29 Inject 40 mg SC every week beginning on day 29	28 day supply	
Remicade® <input type="checkbox"/> 100 mg vial	<input type="checkbox"/> Initial Dose: Infuse _____ mg/kg (_____ mg) IV at weeks 0, 2, and 6 weeks. <input type="checkbox"/> Maintenance Dose: Infuse _____ mg/kg (_____ mg) IV every _____ weeks.	QS	
Rinvoq® <input type="checkbox"/> Starter Kit: 45 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg	<input type="checkbox"/> Initial Dose: Take 45mg po once a day for 8 weeks.	28	1
	<input type="checkbox"/> Maintenance Dose: Take po once a day.	30	
Simponi® <input type="checkbox"/> 100 mg SmartJect <input type="checkbox"/> 100 mg PFS	<input type="checkbox"/> Initial Dose: Inject 200mg SC at week 0, then 100mg at week 2, then maintenance dose	3 units	0
	<input type="checkbox"/> Maintenance Dose: Inject 100mg SC once every 4 weeks	28 day supply	
Stelara® <input type="checkbox"/> 130 mg vial <input type="checkbox"/> 90mg Prefilled Syringe	Initial Dose: Infuse IV over at least 1 hour. <input type="checkbox"/> < 121 lbs 260 mg (2 vials) <input type="checkbox"/> > 121 lbs to 187 lbs 390 mg (3 vials) <input type="checkbox"/> > 187 lbs 520 mg (4 vials)	QS	0
	<input type="checkbox"/> Maintenance Dose: Inject 90 mg SC 8 weeks after initial IV infusion, then every 8 weeks thereafter	QS	
Skyrizi® <input type="checkbox"/> 600 mg vial <input type="checkbox"/> 360 mg PF on-body injector	<input type="checkbox"/> Initial Dose: Infuse 600 mg IV over at least 1 hour on week 0, 4 and 8.	1	2
	<input type="checkbox"/> Maintenance Dose: Inject 360 mg SC at week 12, and every 8 weeks thereafter.	1	
Xeljanz® <input type="checkbox"/> 5 mg tabs <input type="checkbox"/> 10 mg tabs	<input type="checkbox"/> Initial Dose: Take 10 mg PO BID for 8 weeks		
	<input type="checkbox"/> Maintenance Dose: Take 5 mg PO BID <input type="checkbox"/> Maintenance Dose: Take 10 mg PO BID		
Xeljanz XR® <input type="checkbox"/> 11 mg tabs <input type="checkbox"/> 22 mg tabs	<input type="checkbox"/> Initial Dose: Take 22 mg by mouth once daily for 8 weeks		
	<input type="checkbox"/> Maintenance Dose: Take 11 mg by mouth once daily <input type="checkbox"/> Take 22 mg by mouth once daily		
Xifaxan® <input type="checkbox"/> 550mg Tablet	Take 1 tablet by mouth twice a day	60	0
Zeposia® <input type="checkbox"/> 7 Day Titration Pack <input type="checkbox"/> 0.92 Capsules	<input type="checkbox"/> Initial Dose: Take as directed on titration pack.	1	
	<input type="checkbox"/> Maintenance Dose: Take 1 capsule by mouth once a day beginning day 8.	30	
Other:			

Ship Medications To: Physician's Clinic Patient's Home Injection Training Needed: Yes No

Prescriber Signature _____ Date _____ Brand Name Required? Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.