

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: ☐ M ☐ F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____
☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Irritable Bowel Syndrome
 ICD-10: _____
 Other: _____
 Serious or active infection present? ☐ Yes ☐ No
 Hep B ruled out or treatment started? ☐ Yes ☐ No
 TB Test: ☐ Positive ☐ Negative Date: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:

☐ 5-ASA _____
☐ Biologics _____
☐ Corticosteroids _____
☐ Immunosuppressants _____
☐ Methotrexate _____
☐ Surgery _____
☐ Other _____

Indicate Drug Name and Length of Treatment:

4 INJECTION TRAINING: ☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

5 PICK UP OR DELIVERY: ☐ Delivery to Patient's Home ☐ Delivery to Physician's Office ☐ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> Prefilled Syringe Starter Kit <input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg Lyophilized Powder	<input type="checkbox"/> Induction Dose: Inject 400mg SC on day 1, 14 and 28 <input type="checkbox"/> Maintenance: Inject 400mg SC every 4 weeks <input type="checkbox"/> _____	6 2	0
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Crohn's Disease/Ulcerative Colitis Starter Kit <input type="checkbox"/> 80mg/0.8ml Pen <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> Inject two 80mg Pens SC on day 1, then one 80mg Pen SC on day 15 <input type="checkbox"/> Inject one 80mg Pen SC on day 1, then 80mg Pen SC on day 2, then one 80mg Pen SC on day 15 <input type="checkbox"/> Maintenance: Inject 40mg SC every other week <input type="checkbox"/> _____ <input type="checkbox"/> Patient has signed HUMIRA Complete form	3 2	0
<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> 100mg/ml Smartject® Autoinjector <input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose <input type="checkbox"/> Maintenance: Inject 100mg SC every 4 weeks	3 1	0
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 130mg/26ml Vial <input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 90mg/ml Prefilled Syringe <input type="checkbox"/> 45mg/0.5ml Vial	<input type="checkbox"/> Induction Dose: Patient Weight <55kg: 260mg; >55kg to 85kg: 390mg; >85 kg: 520mg administered IV <input type="checkbox"/> Maintenance Dose: Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	1	0
<input type="checkbox"/> UCERIS®	<input type="checkbox"/> 9mg Tablets	<input type="checkbox"/> Take one tablet daily in the morning with or without food	30	1
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> 5mg Tablets <input type="checkbox"/> 10mg Tablets	<input type="checkbox"/> Induction Dose: Take 10mg orally twice daily for 8 weeks <input type="checkbox"/> Maintenance Dose: Take 5mg orally twice daily <input type="checkbox"/> Maintenance Dose: Take 10mg orally twice daily <input type="checkbox"/> _____ <i>Severe renal or moderate hepatic impairment: half the total daily dosage recommended for patients with normal renal and hepatic function</i>		
<input type="checkbox"/> XIFAXAN®	<input type="checkbox"/> 550mg Tablets	<input type="checkbox"/> Take one tablet three times daily for 14 days	42	
<input type="checkbox"/> _____	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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