



PATIENT INFORMATION	Patient Name: _____	PRESCRIBER INFORMATION	Prescriber's Name: _____
	Address: _____		State License #: _____ NPI #: _____
	City: _____ State: _____ Zip: _____		DEA #: _____
	Primary Phone: _____ DOB: _____		Group or Hospital: _____
	Alternate Phone: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Address: _____
	Email: _____		City: _____ State: _____ Zip: _____
	Primary Language: _____		Phone: _____ Fax: _____
	Height: _____ Weight: _____		Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL	Need By Date: _____	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other:
	Date of Diagnosis: _____	Diagnosis ICD-10 Code: Crohn's Disease <input type="checkbox"/> K50.90 Ulcerative Colitis <input type="checkbox"/> K51.90 Other (ICD-10 Code) <input type="checkbox"/> _____
	Previous Medications: _____	
	Current Medications: _____	
	Allergies: _____ Latex Allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Does patient have Active/Serious Infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have Heart Failure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Has patient had a positive TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date of last Chest X-Ray: _____ Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 200mg/mL PFS <input type="checkbox"/> 200mg Vial	<input type="checkbox"/> Induction Dose: Inject 400mg SQ on day 1, 15, and 29 <input type="checkbox"/> Maintenance Dose: Inject 400mg SQ every 4 weeks	<input type="checkbox"/> 1 Starter Kit = 6 PFS <input type="checkbox"/> 2	0
<input type="checkbox"/> Humira® (Citrate-free)	Starter Dose <input type="checkbox"/> 40mg/0.4mL Pen Crohn's Disease, Ulcerative Colitis, Hidradenitis Starter (6 pens) <input type="checkbox"/> 80mg/0.8mL Pen Crohn's Disease, Ulcerative Colitis, Hidradenitis Starter (3 pens) <input type="checkbox"/> 80mg/0.8mL Prefilled Syringe Pediatric Crohn's Disease Starter (3 syringes – for peds ≥ 40 kg) <input type="checkbox"/> 80mg/0.8mL and 40mg/0.4mL Prefilled Syringe Pediatric Crohn's Disease Starter (2 syringes – for peds 17 kg to < 40 kg) <input type="checkbox"/> 80mg/0.8mL Pen Pediatric Ulcerative Colitis Starter (4 pens - for peds ≥ 40 kg) <input type="checkbox"/> 40mg/0.4 mL Pen Pediatric Ulcerative Colitis (4 pens - for peds 20 kg to < 40 kg) <input type="checkbox"/> 40 mg/0.4 mL Prefilled Syringe Pediatric Ulcerative Colitis (4 syringes - for peds 20 kg to < 40 kg)	<input type="checkbox"/> Adult Crohn's/UC and pediatric Crohn's ≥ 40 kg: Inject 160mg SQ on day 1, 80mg SQ on day 15, then 40mg SQ every 14 days thereafter starting on day 29 <input type="checkbox"/> Pediatric Crohn's 17 to < 40 kg: Inject 80mg SQ on day 1, 40mg SQ on day 15, then 20mg SQ every 14 days starting on day 29 <input type="checkbox"/> Pediatric UC ≥ 40 kg: Inject 160mg SQ on day 1, 80mg SQ on day 8, 80mg SQ on day 15, then begin maintenance dosing starting on day 29 <input type="checkbox"/> Pediatric UC 20 kg to < 40 kg: Inject 80mg SQ on day 1, 40mg SQ on day 8, 40mg SQ on day 15, then begin maintenance dosing starting on day 29 <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Kit	0
	Maintenance Dose <input type="checkbox"/> 80mg/0.8mL CF Pen <input type="checkbox"/> 40mg/0.4mL CF Pen <input type="checkbox"/> 40mg/0.4mL CF Prefilled Syringe <input type="checkbox"/> 20mg/0.2mL CF Prefilled Syringe <input type="checkbox"/> 10mg/0.1mL CF Prefilled Syringe	<input type="checkbox"/> Inject 40mg SQ every OTHER week <input type="checkbox"/> Inject 40mg SQ every week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 4 Pens/PFS	_____

X **PHYSICIAN SIGNATURE REQUIRED** **X**

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)
Ancillary supplies and kits will be provided as needed for administration.

Date Needed: _____ Medication Start Date: _____

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MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8mL Pen Crohn's Disease, Ulcerative Colitis, Hidradenitis Starter (6 pens) <input type="checkbox"/> 40mg/0.8mL Prefilled Syringe Pediatric Crohn's Disease Starter (6 syringes) <input type="checkbox"/> 40mg/0.8mL Prefilled Syringe Pediatric Crohn's Disease Starter (3 syringes)	<input type="checkbox"/> Adult Crohn's/UC and pediatric Crohn's ≥ 40 kg: Inject 160mg SQ on day 1, 80mg SQ on day 15, then 40mg SQ every 14 days thereafter starting on day 29 <input type="checkbox"/> Pediatric Crohn's 17 to < 40 kg: Inject 80mg SQ on day 1, 40mg SQ on day 15, then 20mg SQ every 14 days starting on day 29 <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Kit	0
	<input type="checkbox"/> 40mg/0.8mL Pen <input type="checkbox"/> 40mg/0.8mL Prefilled Syringe <input type="checkbox"/> 20mg/0.4mL Prefilled Syringe <input type="checkbox"/> 10mg/0.2mL Prefilled Syringe	<input type="checkbox"/> Inject 40mg SQ every OTHER week <input type="checkbox"/> Inject 40mg SQ every week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 4 Pens/PFS	_____
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Induction: Infuse ____mg IV at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance: Infuse ____mg IV very 8 weeks	<input type="checkbox"/> ____ # Vial(s)	_____
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100mg/mL SmartJect <input type="checkbox"/> 100mg/mL PFS	<input type="checkbox"/> Induction Dose: Inject 200mg SQ day 1, then 100mg SQ on day 15, then 100mg every 4 weeks thereafter	<input type="checkbox"/> 3 Pens/PFS	0
		<input type="checkbox"/> Maintenance Dose: Inject 100mg SQ every 28 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Pens/PFS	_____
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 90mg PFS	<input type="checkbox"/> Maintenance Dose: Inject 90mg SQ every 56 days Has the patient received the IV induction dose already? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date of IV induction dose: _____	<input type="checkbox"/> 1 PFS	_____
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg Tab <input type="checkbox"/> 10mg Tab <input type="checkbox"/> 11mg XR Tab <input type="checkbox"/> 22mg XR Tab	<input type="checkbox"/> Take one 5mg tablet PO twice daily <input type="checkbox"/> Take one 10mg tablet PO twice daily <input type="checkbox"/> Take one 11mg XR tablet PO once daily <input type="checkbox"/> Take one 22mg XR tablet PO once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 60 <input type="checkbox"/> 30	_____
X PHYSICIAN SIGNATURE REQUIRED X				
<input checked="" type="checkbox"/> PRODUCT SUBSTITUTION PERMITTED Ancillary supplies and kits will be provided as needed for administration.		(Date)	<input checked="" type="checkbox"/> DISPENSE AS WRITTEN (Date)	

PRESCRIPTION INFORMATION

Date Needed: _____ Medication Start Date: _____

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