

CROHN'S/UC

PATIENT INFORMATION

Name:		SSN:		DOB:	
Address:		City:	State:	Zip:	
Home Phone:	Cell:	Height:	Weight:	Gender: Female Male	
Email:		Diagnosis Code:			

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

<p>AMJEVITA™ (adalimumab-atto) <input type="checkbox"/> SureClick 40 mg/0.8 mL <input type="checkbox"/> PFS 20 mg/0.4 mL <input type="checkbox"/> PFS 40 mg/0.8 mL Induction: <input type="checkbox"/> 160 mg SUBQ Day 1 <input type="checkbox"/> 4 x 40 mg SUBQ in one day <input type="checkbox"/> 2 x 40 mg SUBQ per day for two consecutive days <input type="checkbox"/> 2 x 40 mg SUBQ Day 15 Qty: 6 Refills: 0 Maintenance: <input type="checkbox"/> 40 mg SUBQ every other week Qty: <input type="text"/> Refills: <input type="text"/></p>	<p>SIMPONI® (golimumab) <input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector Induction: 200 mg (2 x 100 mg) SUBQ at week 0 Qty: 2 syringes Refills: 0</p>
<p>CIMZIA® (certolizumab pegol) <input type="checkbox"/> PFS <input type="checkbox"/> Lyophilized Powder Induction: 400 mg (2 x 200 mg) SUBQ weeks 0, 2, 4 Qty: 28 day supply Refills: 0 Maintenance: <input type="checkbox"/> 2 x 200 mg SUBQ every 4 weeks Qty: 28 day supply Refills: <input type="text"/></p>	<p>SKYRIZI™ (risankizumab-rzaa) <input type="checkbox"/> VIAL Induction: <input type="checkbox"/> 600 mg intravenously weeks 0, 4, 8 <input type="checkbox"/> 1200 mg intravenously weeks 0, 4, 8 Qty: <input type="text"/> Refills: 2 Maintenance: <input type="checkbox"/> OBI <input type="checkbox"/> 180 mg SUBQ starting at week 12, then every 8 weeks <input type="checkbox"/> 360 mg SUBQ starting at week 12, then every 8 weeks Qty: 1 Refills: <input type="text"/></p>
<p>DUPIXENT® (dupilumab) <input type="checkbox"/> PFS <input type="checkbox"/> Pen <input type="checkbox"/> 200 mg/1.14 mL <input type="checkbox"/> 300 mg/2 mL <input type="checkbox"/> 15 kg < 30 kg Inject 200 mg SUBQ every other week <input type="checkbox"/> 30 kg < 40 kg Inject 300 mg SUBQ every other week <input type="checkbox"/> 40 kg or more Inject 300 mg SUBQ every week Qty: 4 for 28 days Refills: <input type="text"/></p>	<p>SOLESTA® (dextranomer and sodium hyaluronate) 1 mL PFS <input type="checkbox"/> 4 submucosal injections Qty: 4 Refills: <input type="text"/></p>
<p>Entocort® (budesonide) 3 mg capsules <input type="checkbox"/> 9 mg PO daily Qty: 90 Refills: <input type="text"/></p>	<p>STELARA® (ustekinumab) IV Induction: <input type="checkbox"/> 260 mg (pt weight: ≤ 55 kg) <input type="checkbox"/> 390 mg (pt weight: 56-85 kg) <input type="checkbox"/> 520 mg (pt weight: >85 kg) Qty: <input type="text"/> Refills: 0 Maintenance: <input type="checkbox"/> Starting 8 weeks after IV induction dose, 90 mg SUBQ every 8 weeks Qty: 1</p>
<p>HUMIRA® (adalimumab) <input type="checkbox"/> Pen <input type="checkbox"/> PFS <input type="checkbox"/> Citrate Free (CF) <input type="checkbox"/> Original Formula Induction: <input type="checkbox"/> 160 mg SUBQ day 1, 80 mg SUBQ day 15 <input type="checkbox"/> 80 mg SUBQ day 1, 80 mg SUBQ day 2/ 80 mg SUBQ day 15 Qty: 1 pack Refills: 0 Maintenance: <input type="checkbox"/> 40 mg SUBQ every other week Qty: 28 day supply Refills: <input type="text"/></p> <p>** If dosage form is not selected, PENS will be dispensed.**</p>	<p>UCERIS® (budesonide) 9 mg Extended-Release Tablet <input type="checkbox"/> 9 mg PO daily Qty: 30 Refills: <input type="text"/></p>
<p>OMVOH™ (mirkizumab-mrkz) <input type="checkbox"/> Vial 20 mg/mL <input type="checkbox"/> PFS 100 mg/mL IV Induction: Inject 300 mg IV at weeks 0, 4, 8 Qty: 1 Refills: 2 <input type="checkbox"/> Maintenance: <input type="checkbox"/> 2 x 100 mg SUBQ weeks 12 and every 4 weeks Qty: 2 PFSs Refills: <input type="text"/></p>	<p>XELJANZ® (tofacitinib) <input type="checkbox"/> Induction: 10 mg PO twice daily for 8-16 weeks Qty: <input type="text"/> Refills: <input type="text"/> <input type="checkbox"/> Maintenance: 5 mg PO twice daily Qty: 60 Refills: <input type="text"/></p>
<p>RINVOQ® (upadacitinib) extended-release tablets <input type="checkbox"/> 45 mg Induction: <input type="checkbox"/> 45 mg PO once daily for 8 weeks <input type="checkbox"/> 45 mg PO once daily for 12 weeks Qty: 30 Refills: <input type="text"/> <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg Maintenance: <input type="checkbox"/> 15 mg PO once daily <input type="checkbox"/> 30 mg PO once daily Qty: <input type="text"/> Refills: <input type="text"/></p>	<p>XIFAXAN® (rifaximin) <input type="checkbox"/> 200 mg tablet <input type="checkbox"/> 550 mg tablet <input type="checkbox"/> 550 mg PO three times per day for 14 days <input type="checkbox"/> 200 mg PO three times per day for 16 days <input type="checkbox"/> _____ mg PO _____ times per day for _____ days Qty: <input type="text"/> Refills: <input type="text"/></p>
<p>IMMUNOSUPPRESSIVE INFUSION <input type="checkbox"/> Biosimilar authorized <input type="checkbox"/> AVSOLA® <input type="checkbox"/> ENTYVIO® <input type="checkbox"/> INFLECTRA® <input type="checkbox"/> Infliximab <input type="checkbox"/> REMICADE® <input type="checkbox"/> RENFLIXIS® <input type="checkbox"/> Initial Dose: _____ mg/kg at week 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: _____ mg/kg every 8 weeks <input type="checkbox"/> Other: _____ mg/kg every _____ weeks Refills: _____</p>	<p>ZEPOSIA® (ozanimod) <input type="checkbox"/> 7-day titration: days 1-4: Give 0.23 mg PO once daily. days 5 to 7: Give 0.46 mg PO daily Qty: 1 Refills: None <input type="checkbox"/> Maintenance Dosing: Starting day 8, 0.92 mg PO once daily Qty: 30 Refills: <input type="text"/></p>

<input type="checkbox"/> OTHER	STRENGTH:	SIG/DIRECTIONS:	REFILLS:	QUANTITY:
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As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PHYSICIAN INFORMATION

Injection Training: Office to Instruct SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:	
Office Contact:	Email:		
Address:	City:	State:	Zip:
NPI #:	Tax ID#:	Ship To:	<input type="checkbox"/> Patient <input type="checkbox"/> MD Office
Prescriber Signature:	Date:		