For assistance, contact your pharmacy representative: _____ Phone: _____ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens + PRIME

Crohn's Disease/Ulcerative Colitis
Prescription/Pharmacy Intake Form

Pharmacy: _____

Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____ City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address: _____ Case Manager: _____

Insurance provider **(Please include copy of front and back of card)**: _____

ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

Will there be access to anaphylactic medications and oxygen at the administration site? _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☐Patient is new to therapy ☐Patient is currently on therapy Start date: _____ ☐Physician Provides Injection Training Injection/Infusion Date: _____

Primary Diagnosis Code and Condition (ICD-10): _____ Other Diagnosis/Conditions: _____

Date of Diagnosis: _____ Current Weight: _____ Date: _____ TB Test Results & Date: _____

☐New Therapy Induction ☐Therapy Change ☐Therapy Continuation | Weeks Completed ☐0 ☐2 ☐4 ☐6 | Stop Date: _____

☐Unresponsive to Conventional Treatment ☐Other Therapies Tried & Failed (Please List): _____

Allergies: _____

Medication	Dose/Directions/Frequency	Quantity	Refills
Cimzia (certolizumab pegol) ☐Starter Kit 6x200mg prefilled syringes			
☐Cimzia 2x200mg vials ☐Cimzia 2x200mg prefilled syringes			
Entyvio (vedolizumab) ☐300mg vial			
Humira (adalimumab) ☐Humira CD/UC/HS Starter Kit 6x40mg pens ☐Humira Pediatric Crohn's Starter Kit 3x40mg prefilled syringes ☐Humira Pediatric Crohn's Starter Kit 6x40mg prefilled syringes			
☐40mg/0.8ml pens ☐40mg/0.8ml prefilled syringes ☐20mg/0.4ml pediatric prefilled syringes			
Humira citrate free (adalimumab) ☐Humira citrate free CD/UC/HS Starter Kit 3x80mg/0.8ml Pens ☐Humira citrate free Pediatric Crohn's Starter Kit 3x80mg/0.8ml PFS ☐Humira citrate free Pediatric Crohn's Starter 1x80mg/0.8ml, 1x40mg/0.4ml PFS ☐Humira citrate free Pediatric Ulcerative Colitis Starter Kit 4x80mg/0.8ml Pens			
☐40mg/0.4ml citrate free pens ☐40mg/0.4ml citrate free prefilled syringes ☐20mg/0.2ml citrate free pediatric prefilled syringes ☐80mg/0.8ml citrate free pens			
Inflectra (infliximab-dyyb) ☐100mg vial			
Remicade (infliximab) ☐100mg vial			
Renflexis (infliximab-abda) ☐100mg vial			
Simponi (golimumab) ☐100mg SmartJect auto injector ☐100mg prefilled syringe ☐Other: _____			
Stelara (ustekinumab) ☐Induction: 130mg/26ml vial			
☐Maintenance: 90mg prefilled syringe ☐Other:			
Tysabri ☐Tysabri – Contact Touch (Biogen Idec) at 1-800-456-2255 or at 1-800-840-1278 (fax)			
Xeljanz (tofacitinib) ☐5mg tablet ☐10mg tablet			
Other: _____			

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.