

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).

Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Fax: _____ Ship To: Prescriber's Office Patient's Home Other: _____

Date Needed: _____

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) <input type="checkbox"/> Starter Kit 6x200mg prefilled syringes <input type="checkbox"/> Cimzia 2x200mg vials <input type="checkbox"/> Cimzia 2x200mg prefilled syringes			
Entyvio (vedolizumab) <input type="checkbox"/> 300mg vial			
Humira (adalimumab) <input type="checkbox"/> Humira CD/UC/HS Starter Kit 6x40mg pens <input type="checkbox"/> Humira Pediatric Crohn's Starter Kit 3x40mg prefilled syringes <input type="checkbox"/> Humira Pediatric Crohn's Starter Kit 6x40mg prefilled syringes <input type="checkbox"/> 40mg/0.8ml pens <input type="checkbox"/> 40mg/0.8ml prefilled syringes <input type="checkbox"/> 20mg/0.4ml pediatric prefilled syringes			
Humira citrate free (adalimumab) <input type="checkbox"/> Humira citrate free CD/UC/HS Starter Kit 3x80mg/0.8ml Pens <input type="checkbox"/> Humira citrate free Pediatric Crohn's Starter Kit 3x80mg/0.8ml PFS <input type="checkbox"/> Humira citrate free Pediatric Crohn's Starter 1x80mg/0.8ml, 1x40mg/0.4ml PFS <input type="checkbox"/> Humira citrate free Pediatric Ulcerative Colitis Starter Kit 4x80mg/0.8ml Pens <input type="checkbox"/> 40mg/0.4ml citrate free pens <input type="checkbox"/> 40mg/0.4ml citrate free prefilled syringes <input type="checkbox"/> 20mg/0.2ml citrate free pediatric prefilled syringes <input type="checkbox"/> 80mg/0.8ml citrate free pens			
Inflixtra (infliximab-dyyb) <input type="checkbox"/> 100mg vial			
Remicade (infliximab) <input type="checkbox"/> 100mg vial			
Renflexis (infliximab-abda) <input type="checkbox"/> 100mg vial			
Rinvoq (upadacitinib) <input type="checkbox"/> 15mg <input type="checkbox"/> 30mg <input type="checkbox"/> 45mg			
Simponi (golimumab) <input type="checkbox"/> 100mg SmartJect auto injector <input type="checkbox"/> 100mg prefilled syringe <input type="checkbox"/> Other: _____			
Skyrizi (risankizumab-rzaa) <input type="checkbox"/> 360 mg/2.4 mL kit <input type="checkbox"/> 600 mg/10 mL			
Stelara (ustekinumab) <input type="checkbox"/> Induction: 130mg/26ml vial <input type="checkbox"/> Maintenance: 90mg prefilled syringe <input type="checkbox"/> Other: _____			
Tysabri <input type="checkbox"/> Tysabri – Contact Touch (Biogen Idec) at 1-800-456-2255 or at 1-800-840-1278 (fax)			
Xeljanz (tofacitinib) <input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet			
Zeposia (ozanimod) <input type="checkbox"/> Starter Kit <input type="checkbox"/> 0.92mg capsules			
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

*** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *** 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. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.