Inflammatory Bowel Disease

Star Discount Pharmacy specialty care

Call: (877) 883-1392 Fax: (256) 429-2221

Patient Information: Name:_____ DOB: _____ Gender M○ F○ Last Four of SS:_____

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

Phone: _____ Alt. Phone: _____ Email: _____ Ht: _____ Wt: _____

Care Giver: _____ Allergies: ○ No Known ○ See Attached Charts Other: _____

Please include front and back copies of insurance card

Prescriber Information

Name: _____ NPI: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State:____ Zip:_____ Office Contact: _____

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: _____

Prior Failed Treatments	Drug Name & Length of Treatment
○ 5-ASA	
○ Biologics	
○ Corticosteroids	
○ Immunosuppressants	
○ Methotrexate	
○ Surgery	
○ Other	

Prescription Information:

Medication	Dosage & Strength	Directions	Qty	Refills
○ Cimzia	○ Prefilled Syringe Starter Kit	○ **Induction Dose:** Inject 400mg SC on day 1, 14, and 28	6	0
	○ 200mg/ml Prefilled Syringe	○ **Maintenance:** Inject 400mg SC every four weeks	2	
○ Humira	○ Crohn's/Ulcerative Colitis 80/0.8ml Starter Pack ○ Crohn's/Ulcerative Colitis 40/0.4ml Starter Pack	**Induction Dose:** ○ Inject two 80mg Pens SC on day 1, then one 80mg Pen SC on day 15 ○ Inject one 80mg Pen SC on day 1, then 80mg Pen SC on day 2, then one 80mg Pen SC on day 15	3 6	0 0
	○ 40mg/0.4ml Pen ○ 40mg/0.4ml Prefilled Syringe	○ **Maintenance**: Inject 40mg SC every other week ○ _____ ○ Patient has signed Humira Complete Form ***All listed strengths and dosages are Citrate Free***	2	
○ Rinvoq	○ 45mg Tablet	○ Take one tablet by mouth daily	30	
○ Simponi	○ 100mg/ml Smartject Autoinjector	○ **Induction Dose:** Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose	3	0
	○ 100mg/ml Prefilled Syringe	○ **Maintenance:** Inject 100mg SC every 4 weeks	1	
○ Skyrizi	○ On Body Injector 360mg/2.4mL Pre-filled Cartridge	○ **Maintenance:** Inject 360mg SC at week 12, and every 8 weeks thereafter	1	
○ Stelara	○ 130mg/26ml Vial	○ Induction Dose: **Weight <55kg**: 260mg; **>55kg to 85kg**: 390mg; **>85kg**: 520mg administered IV		0
	○ 45mg/0.5ml Prefilled Syringe ○ 90mg/ml Prefilled Syringe ○ 45mg/0.5ml Vial	○ Maintenance Dose: Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	1	
○ Xeljanz	○ 5mg Tablets ○ 10mg Tablets	○ **Induction Dose:** Take 10mg orally twice daily for 8 weeks		
		○ **Maintenance Dose:** Take 5mg orally twice daily ○ **Maintenance Dose:** Take 10mg orally twice daily _____ **Severe renal or moderate hepatic impairment: half the total daily dosage recommended for patients with normal renal and hepatic function**		
○ Xifaxan	○ 550mg Tablets	○ Take one tablet three times daily for 14 days	42	

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ 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.

Revised **02/09/2023**