



Patient Information: Name: _____ DOB: _____ Gender: M F
 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
<input type="radio"/> 5-ASA	
<input type="radio"/> Biologics	
<input type="radio"/> Corticosteroids	
<input type="radio"/> Immunosuppressants	
<input type="radio"/> Methotrexate	
<input type="radio"/> Surgery	
<input type="radio"/> Other	

Prescription Information:

Medication	Dosage & Strength	Directions	Qty	Refills
<input type="radio"/> Cimzia	<input type="radio"/> Prefilled Syringe Starter Kit	<input type="radio"/> Induction Dose: Inject 400mg SC on day 1, 14, and 28	6	0
	<input type="radio"/> 200mg/ml Prefilled Syringe	<input type="radio"/> Maintenance: Inject 400mg SC every four weeks	2	
	<input type="radio"/> 200mg Lyophilized Powder			
<input type="radio"/> Humira	<input type="radio"/> Crohn's/Ulcerative Colitis 80/0.8ml Starter Pack	Induction Dose: <input type="radio"/> Inject two 80mg Pens SC on day 1, then one 80mg Pen SC on day 15	3	0
	<input type="radio"/> Crohn's/Ulcerative Colitis 40/0.4ml Starter Pack	<input type="radio"/> Inject one 80mg Pen SC on day 1, then 80mg Pen SC on day 2, then one 80mg Pen SC on day 15	6	0
	<input type="radio"/> 40mg/0.4ml Pen <input type="radio"/> 40mg/0.4ml Prefilled Syringe	<input type="radio"/> Maintenance: Inject 40mg SC every other week <input type="radio"/> _____ <input type="radio"/> Patient has signed Humira Complete Form <i>*All listed strengths and dosages are Citrate Free*</i>	2	
<input type="radio"/> Simponi	<input type="radio"/> 100mg/ml Smartject Autoinjector	<input type="radio"/> Induction Dose: Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose	3	0
	<input type="radio"/> 100mg/ml Prefilled Syringe	<input type="radio"/> Maintenance: Inject 100mg SC every 4 weeks	1	
<input type="radio"/> Stelara	<input type="radio"/> 130mg/26ml Vial	<input type="radio"/> Induction Dose: Weight <55kg: 260mg; >55kg to 85kg: 390mg; >85kg: 520mg administered IV		0
	<input type="radio"/> 45mg/0.5ml Prefilled Syringe	<input type="radio"/> Maintenance Dose: Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	1	
	<input type="radio"/> 90mg/ml Prefilled Syringe <input type="radio"/> 45mg/0.5ml Vial			
<input type="radio"/> Uceris	<input type="radio"/> 9mg Tablets	<input type="radio"/> Take one tablet daily in the morning with or without food.	30	1
<input type="radio"/> Xeljanz	<input type="radio"/> 5mg Tablets	<input type="radio"/> Induction Dose: Take 10mg orally twice daily for 8 weeks		
	<input type="radio"/> 10mg Tablets	<input type="radio"/> Maintenance Dose: Take 5mg orally twice daily <input type="radio"/> _____ <i>*Severe renal or moderate hepatic impairment: half the total daily dosage recommended for patients with normal renal and hepatic function*</i>		
<input type="radio"/> Xifaxan	<input type="radio"/> 550mg Tablets	<input type="radio"/> 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.

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