# Inflammatory Bowel Disease

**Call: (877) 883-1392 Fax: (256) 919-0000**

**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 |
|---|---|
| ○ 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<br>○ 200mg Lyophilized Powder | ○ **Maintenance:** Inject 400mg SC every four weeks | 2 | |
| Humira | ○ Crohn's/Ulcerative Colitis 80/0.8ml Starter Pack<br>Crohn's/Ulcerative Colitis 40/0.4ml Starter Pack | **Induction Dose:**<br>○ Inject two 80mg Pens SC on day 1, then one 80mg Pen SC on day 15<br>○ Inject one 80mg Pen SC on day 1, then 80mg Pen SC on day 2, then one 80mg Pen SC on day 15 | 3<br>6 | 0<br>0 |
| | ○ 40mg/0.4ml Pen<br>○ 40mg/0.4ml Prefilled Syringe | ○ **Maintenance**: Inject 40mg SC every other week<br>_____<br>○ Patient has signed Humira Complete Form<br>***All listed strengths and dosages are Citrate Free*** | 2 | |
| Rinvoq | ○ 45mg Tablet | ○ Take one tablet by mouth daily | 30 | |
| Simponi | ○ 100mg/ml Smartject Autoinjector<br>○ 100mg/ml Prefilled Syringe | ○ Induction Dose: Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose | 3 | 0 |
| | | ○ Maintenance: Inject 100mg SC every 4 weeks | 1 | |
| Stelara | ○ 130mg/26ml Vial | ○ Induction Dose: **Weight <55kg**: 260mg; **>55kg to 85kg**: 390mg; **>85kg**: 520mg administered IV | | 0 |
| | ○ 45mg/0.5ml Prefilled Syringe<br>○ 90mg/ml Prefilled Syringe<br>○ 45mg/0.5ml Vial | ○ Maintenance Dose: Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter | 1 | |
| Uceris | ○ 9mg Tablets | ○ Take one tablet daily in the morning with or without food. | 30 | 1 |
| Xeljanz | ○ 5mg Tablets<br>○ 10mg Tablets | ○ **Induction Dose:** Take 10mg orally twice daily for 8 weeks | | |
| | | ○ **Maintenance Dose:** Take 5mg orally twice daily<br>○ **Maintenance Dose:** Take 10mg orally twice daily<br>_____<br>*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.