

PATIENT INFORMATION

Patient's Name:		SSN:		DOB:	
Address:		City:		State:	Zip:
Home Address:	Cell:	Height:	Weight:		Gender: M F
Email:		Diagnosis Code:			

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

<p>CIMZIA® (certolizumab pegol) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Lyophilized Powder <input type="checkbox"/> Induction: 400 mg (2 x 200 mg) SubQ weeks 0, 2, 4 Qty: 28 day supply Refills: 0 Maintenance: <input type="checkbox"/> 2 x 200 mg SubQ every 4 weeks <input type="checkbox"/> 2 x 200 mg SubQ every 2 weeks <input type="checkbox"/> 200 mg SubQ every 2 weeks Qty: 28 day supply Refills: <input type="text"/></p> <p>Entocort® (budesonide) 3 mg capsules <input type="checkbox"/> 9 mg PO daily Qty: 90 Refills: <input type="text"/></p> <p>ENTYVIO® (vedolizumab) <input type="checkbox"/> Induction: 300 mg intravenously weeks 0, 2, 6 Qty: 1 Refills: 2 <input type="checkbox"/> Maintenance: 300 mg intravenously every 8 weeks Qty: 1 Refills: <input type="text"/></p> <p>HUMIRA® (adalimumab) <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Citrate Free (CF) <input type="checkbox"/> Original Formula Induction: <input type="checkbox"/> 160 mg SubQ day 1, 80 mg SubQ day 15 <input type="checkbox"/> 80 mg SubQ day 1, 80 mg SubQ day 2/ 80 mg SubQ day 15 Qty: 1 pack Refills: 0 <input type="checkbox"/> Maintenance: 40 mg SubQ every other week Qty: 28 day supply Refills: <input type="text"/> ** If dosage form is not selected, PENS will be dispensed.**</p> <p>INFLECTRA® (infliximab) <input type="checkbox"/> Induction: 100 mg vials intravenously weeks 0, 2, 6 <input type="checkbox"/> Maintenance: 100 mg vials intravenously every 8 weeks Qty: 28 day supply Refills: <input type="text"/></p> <p>REMICADE® (infliximab-dyyb) <input type="checkbox"/> Biosimilar authorized if preferred by insurance plan <input type="checkbox"/> 5 mg/kg <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> Induction: 100 mg vials intravenously weeks 0, 2, 6 Refills: 0 Qty: 1 Refills: 0 <input type="checkbox"/> Maintenance: 100 mg vials intravenously every 8 weeks Qty: 28 day supply Refills: <input type="text"/></p> <p>RINVOQ® (upadacitinib) extended-release tablets <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 45 mg <input type="checkbox"/> Induction: 45 mg PO once daily for 8 weeks Qty: 2 bottles Refills: 0 <input type="checkbox"/> Maintenance: _____ mg once daily Qty: <input type="text"/> Refills: <input type="text"/></p>	<p>SIMPONI® (golimumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector <input type="checkbox"/> Induction: 200 mg (2 x 100 mg) SubQ at week 0 Qty: 2 syringes Refills: 0 <input type="checkbox"/> Maintenance: Starting at week 2 of treatment, 100 mg SubQ every 4 weeks Qty: 28 day supply Refills: <input type="text"/></p> <p>SKYRIZI™ (risankizumab-rzaa) <input type="checkbox"/> Induction: 600 mg intravenously weeks 0, 4, 8 Qty: 1 Refills: 0 <input type="checkbox"/> Maintenance: 360 mg SubQ week 12, then every 8 weeks Qty: _____ Refills: <input type="text"/></p> <p>STELARA® (ustekinumab) <input type="checkbox"/> IV Induction: <input type="checkbox"/> 260 mg (pt weight: ≤ 55 kg) <input type="checkbox"/> 390 mg (pt weight: 56-85 kg) <input type="checkbox"/> 520 mg (pt weight: >85 kg) Qty: <input type="text"/> Refills: 0 <input type="checkbox"/> Maintenance: Starting 8 weeks after IV induction dose, 90 mg SubQ every 8 weeks Qty: 1 Refills: <input type="text"/></p> <p>SOLESTA® (dextranomer and sodium hyaluronate) 1 ml Prefilled Syringe <input type="checkbox"/> 4 submucosal injections Qty: 4 Refills: <input type="text"/></p> <p>UCERIS® (budesonide) 9 mg Extended-Release Tablet <input type="checkbox"/> 9 mg PO daily Qty: 30 Refills: <input type="text"/></p> <p>XELJANZ® (tofacitinib) <input type="checkbox"/> Induction: 10 mg PO twice daily for 8-16 week Qty: <input type="text"/> Refills: <input type="text"/> <input type="checkbox"/> Maintenance: 5 mg PO twice daily Qty: 60 Refills: <input type="text"/></p> <p>XIFAXAN® (rifaximin) <input type="checkbox"/> 200 mg tablet <input type="checkbox"/> 550 mg tablet <input type="checkbox"/> 550 mg PO three times per day for 14 days <input type="checkbox"/> 200 mg PO three times per day for 16 days <input type="checkbox"/> _____ mg PO _____ times per day for _____ days Qty: <input type="text"/> Refills: <input type="text"/></p> <p>ZEPOSIA® (ozanimod) <input type="checkbox"/> 7-day titration: days 1-4: Give 0.23 mg PO once daily. days 5 to 7: Give 0.46 mg PO daily Qty: 1 Refills: None <input type="checkbox"/> Maintenance Dosing: Starting day 8, 0.92 mg PO once daily Qty: 30 Refills: <input type="text"/></p>
---	---

<input type="checkbox"/> OTHER	STRENGTH:	SIG/DIRECTIONS:	REFILLS:	QUANTITY:
As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.			<input type="checkbox"/> Dispense as written	

PHYSICIAN INFORMATION Injection Training: Office to Instruct SP to Arrange Teaching

Prescriber Name:		Phone:		Fax:	
Office Contact:			Email:		
Address:				Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office	
NPI #:			Tax ID#:		
Prescription Signature:				Date:	

