

CROHN'S/UC

PATIENT INFORMATION

Name:		SSN:		DOB:	
Address:		City:	State:	ZIP:	
Home Phone:	Cell:	Height:	Weight:	Gender:	Female Male
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)

AMJEVITA[™] (adalimumab-atto) <input type="checkbox"/> SureClick 40 mg/0.8 mL <input type="checkbox"/> PFS 20 mg/0.4 mL <input type="checkbox"/> PFS 40 mg/0.8 mL Induction: <input type="checkbox"/> 160 mg SUBQ Day 1 <input type="checkbox"/> 4 x 40 mg SUBQ in one day <input type="checkbox"/> 2 x 40 mg SUBQ per day for two consecutive days <input type="checkbox"/> 2 x 40 mg SUBQ Day 15 Qty: 6 Refills: 0 Maintenance: <input type="checkbox"/> 40 mg SUBQ every other week Qty: <input type="text"/> Refills: <input type="text"/>	OMVOH[™] (mirikizumab-mrkz) <input type="checkbox"/> Vial 20 mg/mL <input type="checkbox"/> PFS 100 mg/mL <input type="checkbox"/> IV Induction: Inject 300 mg IV at weeks 0, 4, 8 Qty: 1 Refills: 2 Maintenance: <input type="checkbox"/> 2 x 100 mg SUBQ weeks 12 and every 4 weeks Qty: 2 PFS Refills: <input type="text"/>	SOLESTA[®] (dextranomer and sodium hyaluronate) 1 mL PFS <input type="checkbox"/> 4 submucosal injections Qty: 4 Refills: <input type="text"/>
CIMZIA[®] (certolizumab pegol) <input type="checkbox"/> PFS <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 Qty: 28 day supply Refills: <input type="text"/>	RINVOQ[®] (upadacitinib) extended-release tablets <input type="checkbox"/> 45 mg Induction: <input type="checkbox"/> 45 mg PO once daily for 8 weeks <input type="checkbox"/> 45 mg PO once daily for 12 weeks Qty: 28 Refills: <input type="text"/>	STELARA[®] (ustekinumab) IV Induction: Single dose starting at week 0 <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 Maintenance: <input type="checkbox"/> Starting 8 weeks after IV induction dose, 90 mg SUBQ every 8 weeks Qty: 1 Refills: <input type="text"/>
DUPIXENT[®] (dupilumab) <input type="checkbox"/> PFS <input type="checkbox"/> Pen <input type="checkbox"/> 200 mg/1.14 mL <input type="checkbox"/> 300 mg/2 mL <input type="checkbox"/> 15 kg < 30 kg inject 200 mg SUBQ every other week <input type="checkbox"/> 30 kg < 40 kg inject 300 mg SUBQ every other week <input type="checkbox"/> 40 kg or more inject 300 mg SUBQ every other week Qty: 4 for 28 days Refills: <input type="text"/>	SIMLANDI[®] (adalimumab-ryvk) <input type="checkbox"/> 40 mg/0.4 mL Autoinjector <input type="checkbox"/> Induction: 160 mg SUBQ on Day 1 Qty: 3 syringes Refills: 0 Maintenance: <input type="checkbox"/> 80 mg on Day 15 and 40 mg every other week starting on Day 29. Qty: <input type="text"/> Refills: <input type="text"/>	TREMFYA[®] (guselkumab) <input type="checkbox"/> PFS <input type="checkbox"/> Pen Induction: <input type="checkbox"/> 200 mg IV infused weeks 0, 4, and 8 <input type="checkbox"/> Induction Pack: 2x200 mg SUBQ at weeks 0, 4, and 8 Qty: <input type="text"/> Refills: <input type="text"/>
Entocort[®] (budesonide) 3 mg capsules <input type="checkbox"/> 9 mg PO daily Qty: 90 Refills: <input type="text"/>	SIMPONI[®] (golimumab) <input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector <input type="checkbox"/> Induction: 200 mg (2 x 100 mg) SUBQ at week 0 Qty: 2 syringes Refills: 0 Maintenance: <input type="checkbox"/> Starting at week 2 of treatment, 100 mg SUBQ every 4 weeks Qty: <input type="text"/> Refills: <input type="text"/>	UCERIS[®] (budesonide) 9 mg Extended-Release Tablet <input type="checkbox"/> 9 mg PO daily Qty: 30 Refills: <input type="text"/>
HUMIRA[®] (adalimumab) <input type="checkbox"/> Pen <input type="checkbox"/> PFS <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 Maintenance: <input type="checkbox"/> 40 mg SUBQ every other week Qty: 28 day supply Refills: <input type="text"/>	SKYRIZI[™] (risankizumab-rzaa) <input type="checkbox"/> VIAL Induction: <input type="checkbox"/> 600 mg intravenously weeks 0, 4, 8 <input type="checkbox"/> 1,200 mg intravenously weeks 0, 4, 8 Qty: <input type="text"/> Refills: 2 Maintenance: <input type="checkbox"/> OBI <input type="checkbox"/> 180 mg SUBQ starting at week 12, then every 8 weeks <input type="checkbox"/> 360 mg SUBQ starting at week 12, then every 8 weeks Qty: 1 Refills: <input type="text"/>	XELJANZ[®] (tofacitinib) <input type="checkbox"/> Induction: 10 mg PO twice daily for 8-16 weeks Qty: <input type="text"/> Refills: <input type="text"/>
** If dosage form is not selected, PENS will be dispensed.**		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"/>
		ZEPOSIA[®] (ozanimod) <input type="checkbox"/> 7-day titration: days 1-4: Give 0.23 mg PO daily; days 5-7: Give 0.46 mg PO daily Qty: 1 Refills: None Maintenance Dosing: Starting day 8, 0.92 mg PO daily Qty: 30 Refills: <input type="text"/>

IMMUNOSUPPRESSIVE INFUSION <input type="checkbox"/> Biosimilar authorized <input type="checkbox"/> AVSOLA [®] <input type="checkbox"/> ENTYVIO [®] <input type="checkbox"/> INFLECTRA [®] <input type="checkbox"/> Infliximab <input type="checkbox"/> REMICADE [®] <input type="checkbox"/> RENFLEXIS [®] Initial Dose: _____ mg/kg at week 0, 2, and 6 Maintenance Dose: _____ mg/kg every 8 weeks Other: _____ mg/kg every _____ weeks Refills: _____	
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<input type="checkbox"/> OTHER	STRENGTH:	SIG/DIRECTIONS:	REFILLS:	QUANTITY:
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As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.

☐ Dispense as written

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

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