Crohn's Disease / Ulcerative Colitis

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Crohn's Disease:
☐ K50.0 (Crohn's Disease of the Small Intestine) ☐ K50.1 (Crohn's Disease of the Large Intestine)
☐ K50.8 (Crohn's Disease of Both Intestines) ☐ K50.9 (Crohn's Disease, unspecified)

Ulcerative Colitis:
☐ K51.0 (Ulcerative Pancolitis) ☐ K51.2 (Ulcerative Procolitis) ☐ K51.3 (Ulcerative Rectosigmoiditis)
☐ K51.5 (Left Sided Colitis) ☐ K51.8 (Other Ulcerative Colitis) ☐ K51.9 (Ulcerative Colitis, unspecified)

Other: ☐ _____

Diagnosis Date: _____ TB Test: ☐ Yes ☐ No Neg. Test Date: _____

Prior Therapy ☐ Yes ☐ No _____

Reason for Discontinuation of Therapy _____

Approximate Start Date _____ Approximate End Date _____

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other:

Prescription	Directions	Quantity	Form	Refills
☐ **Cimzia®** (certolizumab)	☐ Inject 400 mg subq at weeks 0, 2 and 4	☐ 6 x 200 mg/mL	☐ PFS ☐ Vials	0
	☐ Inject 400 mg subq every 4 weeks	☐ 2 x 200 mg/mL	☐ PFS ☐ Vials	
☐ **Humira®** (adalimumab) *Adults*	☐ Inject 160 mg subq on day 1, then 80 mg on day 15	☐ 6 x 40 mg/0.8mL	☐ Pens ☐ PFS	0
	☐			
	☐ Inject 40 mg subq on day 29 and every other week thereafter	☐ 2 x 40 mg/0.8mL	☐ Pens ☐ PFS	
☐ **Entyvio®** (vedolizumab)	☐ Infuse 300mg intravenously at weeks 0 and 2	☐ 2 x 300mg	☐ Vials	0
	☐ Infuse 300mg intravenously at week 6 then every 8 weeks thereafter	☐ 1 x 300mg		
☐ **Humira®** (adalimumab) *Pediatrics ≥ 6 years*	☐ Inject 80 mg subq day 1, then 40 mg on day 15 (17 to <40 kg)	☐ 3 x 40 mg/0.8mL	☐ Pens ☐ PFS	0
	☐ Inject 160 mg subq day 1, then 80 mg on day 15 (≥40 kg)	☐ 6 x 40 mg/0.8mL		
	☐			
	☐ Inject 20 mg subq on day 29 and every other week thereafter (17 to <40 kg)	☐ 2 x 20 mg/0.4mL	☐ PFS	
	☐ Inject 40 mg subq on day 29 and every other week thereafter (≥40 kg)	☐ 2 x 40 mg/0.8mL	☐ Pens ☐ PFS	
☐ **Inflectra®** (infliximab) ☐ **Renflexis®** (infliximab)	☐ Infuse 5mg/kg at weeks 0 and 2	☐ 100mg	☐ Vials	0
	☐ Infuse 5mg/kg at week 6 and then every 8 weeks thereafter			
☐ **Remicade®** (infliximab)	☐ Infuse 5mg/kg at weeks 0 and 2	☐ 100mg	☐ Vials	0
	☐ Infuse 5mg/kg at week 6 and then every 8 weeks thereafter			
☐ **Simponi®** (golimumab)	☐ Inject 200 mg subq at week 0, then 100 mg at week 2	☐ 3 x 100 mg/mL	☐ SmartJect® Autoinjector ☐ PFS	0
	☐ Inject 100 mg subq every 4 weeks	☐ 1 x 100 mg/mL	☐ SmartJect® Autoinjector ☐ PFS	
☐ **Stelara®** (ustekinumab)	☐ Infuse 260 mg intravenously over no less than one hour (≤55kg)	☐ 2 x 130 mg/26 mL	☐ Vials	0
	☐ Infuse 390 mg intravenously over no less than one hour (>55 kg to <85 kg)	☐ 3 x 130 mg/26 mL		
	☐ Infuse 520 mg intravenously over no less than one hour (>85 kg)	☐ 4 x 130 mg/26mL		
	☐ Inject 90 mg subq 8 weeks following initial intravenous dose, then every 8 weeks thereafter	☐ 1 x 90 mg/mL	☐ PFS	
	Patient eligible for self-administration? ☐ Yes ☐ No			
	Date of last infusion: _____			
☐ **Tysarbi®** (natalizumab)	☐ Infuse 300mg intravenously over 1 hour every 4 week	☐ 1 x 300mg	☐ Vials	
☐ **Xifaxan®** (rifaximin)	☐ Irritable Bowel Syndrome with Diarrhea: Take one tablet by mouth 3 times a day for 14 days	☐ 42 x 550mg	☐ Tablets	
	☐ Hepatic Encephalopathy: Take one tablet by mouth 2 times a day	☐ 60 x 550mg	☐ Tablets	

Injection training provided by: ☐ Physician's Office ☐ Pharmacy ☐ Other:

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

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