

Patient Information	Prescriber & Shipping Information
Patient Name: _____ DOB: _____	Prescriber Name: _____
Sex: <input type="radio"/> Female <input type="radio"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="radio"/> kg <input type="radio"/> lbs Ht: _____ <input type="radio"/> cm <input type="radio"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate Phone: _____	Phone: _____ Alternate Phone: _____
Caregiver Name: _____ Relation: _____	Fax: _____
Local Pharmacy: _____ Phone: _____	Email: _____
	<input type="checkbox"/> Ship to Physician's Office <input type="checkbox"/> Ship to Patient's Home

Please fax a front and back copy of the Patient's Insurance Card(s)

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

Diagnosis: K50.90 Crohn's Disease K51.90 Ulcerative Colitis Other: _____

Has patient received PPD (skin test)? Yes No Results: _____

Prior Therapy No Yes List: _____ Reason for Discontinuation: _____

Approximate Start Date: _____ Approximate Stop Date: _____

Comorbidities: _____

Concomitant Medications: _____

Allergies NKDA Other : _____ Is this a first dose? Y N If not, date of last infusion: _____

Drug	How Supplied	Directions	Quantity	Refill
Entyvio®	<input type="radio"/> 300mg vial	<input type="radio"/> Loading dose: Infuse 300mg IV over 30 minutes at week 0, week 2, and week 6	<input type="radio"/> 3 doses	_____
		<input type="radio"/> Maintenance dose: Infuse 300mg IV over 30 minutes every 8 weeks	<input type="radio"/> _____ doses	
		<input type="radio"/> Other: Infuse 300mg IV over 30 minutes every _____ weeks		
Infliximab	<input type="radio"/> 100mg vial <input type="radio"/> Dispense vials necessary to achieve dose	<input type="radio"/> Loading dose: Infuse _____mg/kg IV over 2 hours at week 0, week 2, and week 6	<input type="radio"/> 3 doses	_____
		<input type="radio"/> Maintenance dose: Infuse _____mg/kg IV over 2 hours every _____ weeks	<input type="radio"/> _____doses	
		Patient Weight: _____kg		
Skyrizi® (Induction dose)	<input type="radio"/> 600mg/10ml vial	<input type="radio"/> Crohn's Loading Dose: Infuse 600mg IV over 1 hour at week 0, week 4, and week 8	<input type="radio"/> 3 vials	_____
		<input type="radio"/> Ulcerative Colitis Loading Dose: Infuse 1200mg IV over 2 hours at week 0, week 4, and week 8	<input type="radio"/> 6 vials	
Skyrizi® SubQ	<input type="radio"/> 180mg/1.2ml	<input type="radio"/> Maintenance dose: 180mg SubQ every 8 weeks starting at week 12 after the initial IV induction dose	<input type="radio"/> 1 dose	_____
	<input type="radio"/> 360mg/2.4ml	<input type="radio"/> Maintenance dose: 360mg SubQ every 8 weeks starting at week 12 after the initial IV induction dose		
Stelara® (Induction dose)	<input type="radio"/> 130mg/26ml vial	<input type="radio"/> Low-Dose induction: Infuse 130mg IV over at least 1 hour	<input type="radio"/> 1 vial	_____
		<input type="radio"/> ≤ 55kg: Infuse 260mg IV over at least 1 hour	<input type="radio"/> 2 vials	
		<input type="radio"/> > 55kg to 85kg: Infuse 390 mg IV over at least 1 hour	<input type="radio"/> 3 vials	
		<input type="radio"/> >85kg: Infuse 520mg IV over at least 1 hour	<input type="radio"/> 4 vials	
Stelara® SubQ	<input type="radio"/> 1 x 90mg/ml PFS	<input type="radio"/> Inject 90mg SubQ 8 weeks after initial IV dose and then every 8 weeks thereafter	<input type="radio"/> 1 syringe	_____
Tysabri®	<input type="radio"/> 300mg/15ml vial	<input type="radio"/> Infuse 300mg IV over 1 hour every 4 weeks	<input type="radio"/> 1 vial	_____
TPN (Total Parenteral Nutrition) in the home setting: Please send orders separately.				
Other Miscellaneous Orders: _____			<input type="radio"/> _____	_____
Other Miscellaneous Orders: _____			<input type="radio"/> _____	_____
Injection Training Provided by: <input type="radio"/> Physician's Office <input type="radio"/> Pharmacy <input type="radio"/> Other:				
Per state-specific law, prescriptions may be dispensed as generic, if applicable, unless marked "dispense as written"				
Prescriber's Signature _____			Date: _____	

I authorize the Pharmacy 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 anytime by providing written notice to the pharmacy. Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from dissemination or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling (888) 860-8806 to obtain instructions as to proper destruction of the transmitted material. Thank you.