



Patient Information – Please attach a copy of the patient's insurance card

Patient Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City:	State:	Zip:
Phone Number:	Alternate Phone Number:		Language:	
Allergies (Required):	<input type="checkbox"/> NKDA	Height:	Weight:	SSN:

Product Shipping Options: ☐ Patient's Home ☐ Prescriber Office ☐ Alternative Address:

Prescriber Information

Practice Name:		Office Contact:	
Prescriber :		NPI:	DEA:
Practice Address:		City:	State: Zip:
Phone Number:		Fax Number:	

Clinical Information – Please send all available chart notes including lab results

Diagnosis/ICD -10:	Prior Failed Medications:
Is Hepatitis B ruled out? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, has treatment started? <input type="checkbox"/> Yes <input type="checkbox"/> No	TB/PPD test given/intended to be given before start? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach all available lab results :

Prescription Information

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Prefilled syringe starter kit <input type="checkbox"/> 200 mg/mL prefilled syringe	Induction dose: 400 mg Sub-Q at weeks 0, 2, and 4 Maintenance dose: <input type="checkbox"/> 400 mg Sub-Q every 4 weeks <input type="checkbox"/> 200 mg Sub-Q every 2 weeks	<input type="checkbox"/> 1 starter kit (6 prefilled syringes) <input type="checkbox"/> 1 unit (2 prefilled syringes)	0
<input type="checkbox"/> Donnatal®	<input type="checkbox"/> 16.2 mg/5 mL Elixir <input type="checkbox"/> 16.2 mg tablets	<input type="checkbox"/> Take _____ mL by mouth _____ daily (elixir) <input type="checkbox"/> Take _____ tablets by mouth _____ times daily	<input type="checkbox"/> 118 mL <input type="checkbox"/> 473 mL <input type="checkbox"/> 90 tablets <input type="checkbox"/> 240 tablets <input type="checkbox"/> _____ tablets	
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300 mg vial	<input type="checkbox"/> 300 mg infused IV at 0, 2 and 6 weeks, then every 8 weeks thereafter.	____# of 300 mg vials	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 80 mg pens CF <input type="checkbox"/> 40 mg pens CF <input type="checkbox"/> 40 mg prefilled syringe CF	Induction dose: <input type="checkbox"/> Adults and children * 88 lbs.: 160 mg Sub -Q day 1, 80 mg day 15 , 40 mg day 29 and every other week thereafter Maintenance dose: <input type="checkbox"/> Adults and children * 88 lbs.: 40 mg Sub -Q every other week	<input type="checkbox"/> 1 starter (3 pens) <input type="checkbox"/> 1 unit (2 pens) <input type="checkbox"/> 1 unit (2 prefilled syringes)	0
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg/mL SmartJect® <input type="checkbox"/> 100 mg/mL prefilled syringe	Induction dose: <input type="checkbox"/> 200 mg Sub-Q at week 0, 100 mg at week 2 and every 4 weeks thereafter Maintenance dose: <input type="checkbox"/> 100 mg Sub -Q every 4 weeks	<input type="checkbox"/> 3 SmartJect® autoinjectors <input type="checkbox"/> 3 prefilled syringes <input type="checkbox"/> 1 SmartJect® autoinjector <input type="checkbox"/> 1 prefilled syringe	0
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 90 mg prefilled syringe	Induction dose date: _____ \ _____ \ _____ Maintenance dose: <input type="checkbox"/> Inject 1 syringe Sub -Q every 8 weeks after induction	1 prefilled syringe	
<input type="checkbox"/> Xifaxan®	<input type="checkbox"/> 200 mg tablets <input type="checkbox"/> 550 mg tablets	<input type="checkbox"/> Take one tablet by mouth three times daily for three days (Travelers' Diarrhea) <input type="checkbox"/> Take one tablet by mouth twice daily with or without food (Hepatic Encephalopathy) <input type="checkbox"/> Take one tablet by mouth three times daily for 14 days (IBS-D)	<input type="checkbox"/> 9 tablets <input type="checkbox"/> 42 tablets <input type="checkbox"/> 60 tablets	
<input type="checkbox"/> Uceris®	<input type="checkbox"/> 9mg tablets <input type="checkbox"/> 2mg/dose foam	<input type="checkbox"/> Take one tablet by mouth once daily in the morning with or without food <input type="checkbox"/> Insert and administer 1 metered dose twice daily for two weeks followed by 1 metered dose once daily (foam)	<input type="checkbox"/> 30 tablets <input type="checkbox"/> 60 tablets <input type="checkbox"/> 2 week supply <input type="checkbox"/> 6 week supply	

Other Medications

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Amitiza®	<input type="checkbox"/> 24 mcg capsules <input type="checkbox"/> 8 mcg capsules	<input type="checkbox"/> Take one 24 mcg capsule twice daily (CIC & OIC) <input type="checkbox"/> Take one 8 mcg capsule twice daily (IBS-C)	60 capsules	
<input type="checkbox"/> Linzess®	<input type="checkbox"/> 72 mcg capsules <input type="checkbox"/> 145 mcg capsules <input type="checkbox"/> 290 mcg capsules	<input type="checkbox"/> Take one capsules by mouth daily	30 tablets	
<input type="checkbox"/> Movantik®	<input type="checkbox"/> 25 mg tablets	<input type="checkbox"/> Take 1 tablet by mouth daily in the morning	90 tablets	
<input type="checkbox"/> Relistor®	<input type="checkbox"/> 150 mg tablets	<input type="checkbox"/> Take 3 tablets by mouth daily	90 tablets	
<input type="checkbox"/> Trulance®	<input type="checkbox"/> 3 mg tablets	<input type="checkbox"/> Take one tablet by mouth daily	30 tablets	
<input type="checkbox"/> Other				

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: _____
Date _____

