

INFLAMMATORY BOWEL DISEASE SPECIALTY CARE PROGRAM

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____
 Crohn's Disease Ulcerative Colitis Irritable Bowel Syndrome
 ICD-10: _____
 Other: _____
 Serious or active infection present? Yes No
 Hep B ruled out or treatment started? Yes No
 TB Test: Positive Negative Date: _____
 Pregnancy test : Positive Negative Date: _____

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> 5-ASA	_____
<input type="checkbox"/> Biologics	_____
<input type="checkbox"/> Corticosteroids	_____
<input type="checkbox"/> Immunosuppressants	_____
<input type="checkbox"/> Methotrexate	_____
<input type="checkbox"/> Surgery	_____
<input type="checkbox"/> Other	_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> 200mg Lyophilized Powder <input type="checkbox"/> 200mg mg/ml single-dose Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 400mg SC on day 1, 14 and 28 <input type="checkbox"/> Maintenance: Inject 400mg SC every 4 weeks	6 2	0
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Crohn's Disease/Ulcerative Colitis 80mg/0.8ml Starter Package <input type="checkbox"/> Crohn's Disease/Ulcerative Colitis 40mg/0.4ml Starter Package <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 80mg/0.8ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe <input type="checkbox"/> 80mg/0.8ml Prefilled Syringe All strengths and dosages listed are Humira® Citrate Free	<input type="checkbox"/> Crohn's disease/ulcerative colitis for adult patients: <input type="checkbox"/> Induction Dose: Inject 160mg on day 1 and 80mg on day 15 <input type="checkbox"/> Maintenance Dose: Inject 40mg every other week starting on day 29 <input type="checkbox"/> Maintenance: Inject 40mg SC every other week <input type="checkbox"/> Patient has signed HUMIRA Complete form	3 2	
<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> 100mg/ml Smartject® Autoinjector <input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose <input type="checkbox"/> Maintenance: Inject 100mg SC every 4 weeks	3 1	0
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 130mg/26ml Vial <input type="checkbox"/> 90mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Patient Weight <55kg: 260mg; >55kg to 85kg: 390mg; >85 kg: 520mg administered IV <input type="checkbox"/> Maintenance Dose: Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	1	0
<input type="checkbox"/> SKYRIZI®	<input type="checkbox"/> 600 mg/10 ml (60 mg/ml) in each single-dose vial <input type="checkbox"/> 360 mg/2.4 ml (150 mg/ml) single-dose prefilled cartridge	<input type="checkbox"/> Induction Dose: 600 mg by intravenous infusion over a period of at least one hour at Week 0, Week 4, and Week 8 <input type="checkbox"/> Maintenance dose: 360 mg by subcutaneous injection at Week 12, and every 8 weeks thereafter		
<input type="checkbox"/> UCERIS®	<input type="checkbox"/> 9mg ER Tablets	<input type="checkbox"/> Take one 9mg tablet once daily in the morning with or without food for up to 8 weeks		
<input type="checkbox"/> RINVOQ® XR	<input type="checkbox"/> 45mg ER Tablet <input type="checkbox"/> 15mg ER Tablet <input type="checkbox"/> 30mg ER Tablet	<input type="checkbox"/> Induction Dose: Take 45mg orally once daily for 8 weeks <input type="checkbox"/> Maintenance Dose: Take 15mg orally once daily <input type="checkbox"/> Take 30mg orally once daily (Considered for patients with refractory, severe, or extensive disease) "If an adequate response is not achieved, consider increasing the dosage to 30mg orally once daily."		
<input type="checkbox"/> _____				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> VIBERZI®	<input type="checkbox"/> 100mg Tablet <input type="checkbox"/> 75mg Tablet	<input type="checkbox"/> 100mg orally twice a day with food <input type="checkbox"/> 75mg orally twice a day with food (Who is unable to tolerate the 100 mg dose, mild or moderate hepatic impairment, moderate or severe renal impairment, and end stage renal disease not yet on dialysis) "Discontinue if the patients develop severe constipation"	60	
<input type="checkbox"/> XELJANZ® <input type="checkbox"/> XELJANZ® XR	<input type="checkbox"/> 5mg Tablet <input type="checkbox"/> 10mg Tablet <input type="checkbox"/> 22mg Tablet <input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> Take 10mg orally twice daily for at least 8 weeks <input type="checkbox"/> Take 22mg orally once daily for at least 8 weeks <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Take 5mg orally twice daily <input type="checkbox"/> Take 10mg orally twice daily <input type="checkbox"/> Take 11mg orally once daily "Moderate and severe renal impairment or moderate hepatic impairment reduce dose to 5mg once daily or 11mg once daily."		
<input type="checkbox"/> XIFAXAN®	<input type="checkbox"/> 550mg Tablets	<input type="checkbox"/> Take one tablet three times daily for 14 days	42	
<input type="checkbox"/> YUSIMRY™	Ulcerative Colitis (UC) <input type="checkbox"/> 40mg/0.8ml Single-Dose Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 160mg SC on day 1 and 80mg on day 15 <input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week starting on day 29		
<input type="checkbox"/> ZEPOSIA®	<input type="checkbox"/> 0.23mg <input type="checkbox"/> 0.46mg <input type="checkbox"/> 0.92mg	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> Take 0.23mg once daily on days 1-4 <input type="checkbox"/> Take 0.46mg once daily on days 5-7 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Take 0.92mg orally once daily on day 8 and thereafter	30	
<input type="checkbox"/> _____	_____	_____		

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Signature: _____ Date: _____ Signature: _____ Date: _____

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