



## Crohn's Order Form

2506 Lakeland Drive, Suite 201, Jackson, Mississippi 39232  
 Pharmacy phone: (866) 420-4041 Pharmacy fax: (601) 420-4040  
 www.transcriptpharmacy.com

### Patient Information

Patient name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Cell \_\_\_\_\_  
 DOB \_\_\_\_\_ SSN \_\_\_\_\_  
 Drug allergies \_\_\_\_\_  Male  Female

### Prescriber Information

Prescriber name \_\_\_\_\_ Lic# \_\_\_\_\_  
 DEA# \_\_\_\_\_ Tax ID \_\_\_\_\_  
 Practice name \_\_\_\_\_  
 Address \_\_\_\_\_ Suite \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Fax \_\_\_\_\_

### Insurance, Medicare or Medicaid Information

Primary Insurance \_\_\_\_\_ Secondary Insurance (If applicable) \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group \_\_\_\_\_ Policy # \_\_\_\_\_ Group \_\_\_\_\_  
 Insurance phone \_\_\_\_\_ Insurance phone \_\_\_\_\_  
 Prescription Drug Coverage: Company \_\_\_\_\_ Phone \_\_\_\_\_  
 RXGRP# \_\_\_\_\_ RXBIN# \_\_\_\_\_ PCN/ID# (if avail.) \_\_\_\_\_

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

### Clinical Information

Diagnosis:  555.9 Crohn's disease NOS  556.9 Ulcerative Colitis  Other \_\_\_\_\_ TB/PPD test given?  Yes  No Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please indicate current or previous treatments and treatment duration below:

NSAIDS Duration: \_\_\_\_\_  Current Therapy  Failed  Sulfasalazine Duration: \_\_\_\_\_  Current Therapy  Failed  
 Corticosteroids Duration: \_\_\_\_\_  Current Therapy  Failed  5-ASA Duration: \_\_\_\_\_  Current Therapy  Failed  
 Methotrexate Duration: \_\_\_\_\_  Current Therapy  Failed  6-MP Duration: \_\_\_\_\_  Current Therapy  Failed  
 Azathioprine Duration: \_\_\_\_\_  Current Therapy  Failed  Other \_\_\_\_\_ Duration: \_\_\_\_\_  Current Therapy  Failed

Failed Biologic(s) & Duration of Each: \_\_\_\_\_

Other medications patient is currently taking including OTC medications with dosage and directions (or fax Rx profile) \_\_\_\_\_

Will patient stop taking the above medications before starting the new medication?  Yes  No If YES, what is the washout period? \_\_\_\_\_

Drug name	Prescription Orders (PLEASE CHECK ONE OR MORE)	Quantity	Refills
Cimzia® <input type="radio"/> Prefilled syringe (PFS) <input type="radio"/> Lyophilized powder (LYO)	<input type="radio"/> Initial dose of 400mg SC at weeks 0, 2 and 4, then maintenance dosing (below) <input type="radio"/> Maintenance dose of 400mg SC every 4 weeks	28 day supply	Refills
<input type="radio"/> Humira® Pen	<input type="radio"/> Induction: inject 160mg (4pens) SC on day 1, then 80mg (2pens) on day 15, then maintenance dosing (below) <input type="radio"/> Maintenance: inject 40mg SC (1pen) SC every other week [OR] <input type="radio"/> Other: _____	28 day supply	Refills
<input type="radio"/> Remicade® 100mg vial	Directions _____	28 day supply	Refills
Other Medications:	Directions _____	Qty	Refills
Other Medications:	Directions _____	Qty	Refills

Deliver to:  Patient's home  MD's office  1<sup>st</sup> dose to MD's office, remaining refills to patient home Injection training needed?  Yes  No

We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

\_\_\_\_\_  
 Prescriber name or signature Office Contact Name (Nurse, MA, Other) Preferred phone number & extension Date