Crohn's and Ulcerative Colitis Order Form

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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 ______________________________

Policy # ____________ Group ____________

Insurance phone ______________________________

Secondary Insurance(*If applicable*,) ______________________________

Policy # ____________ Group ____________

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® ❍Prefilled syringe (PFS) ❍Lyophilized powder (LYO)	❍**Initial** dose of 400mg SC at weeks 0, 2 and 4, then maintenance dosing (below) ❍**Maintenance** dose of 400mg SC every 4 weeks	28 day supply	Refills
❍Humira® Pen	❍**Induction**: inject 160mg (4pens) SC on day 1, then 80mg (2pens) on day 15, then maintenance dosing (below) ❍**Maintenance**: inject 40mg SC (1pen) SC every other week [OR] ❍ Other: ____________	28 day supply	Refills
❍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 ❍ 1st 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**