



Crohn's Disease/Ulcerative Colitis Form

Northborough, MA: Toll free (855) 880-1091 Toll free fax (844) 265-0265

www.AllCarePlusPharmacy.com

DATE: _____ THERAPY START DATE: _____ DELIVERY : PATIENT OFFICE OTHER: _____

PATIENT INFO		
Patient Name		
Address		
City, State, Zip		
Phone		
Social Security	Hgt.	Wt.
Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female

PRESCRIBER INFO	
Prescriber Name	
DEA/NPI #	
Preparer Name/Office Contact	
Address	
City, State, Zip	
Phone	Fax

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Crohn's Disease ICD-10 Code: _____

Ulcerative Colitis ICD-10 Code: _____

Diagnosis Date: _____ Other: _____

Has patient received a PPD (tuberculosis) Skin Test?
 Yes No Results: _____

Has patient been treated previously for this condition?
 Yes No Medication(s): _____

Is this patient currently on therapy? Yes No

Medication(s): _____

Other medications patient is currently taking including OTC medications with dosage and directions (or fax medication profile): _____

ALLERGIES: _____

PRESCRIPTION INFORMATION

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Cimzia® Prefilled Syringe (2 Prefilled Syringe PFS of 200 mg/mL)	<input type="checkbox"/> Initial Dose: 400 mg SQ (2 injections of 200 mg) On day 1, repeat at weeks 2 and 4 Note: Cimzia Prefilled Syringe Starter Kit will be dispensed unless MD request for Cimzia Vial		<input type="checkbox"/> 1 kit (6 PFS)	
<input type="checkbox"/> Cimzia® vial (2 vials of 200 mg powder) <small>Note: Cimzia vial should be prepared and administered by a health care professional.</small>	<input type="checkbox"/> Maintenance: <input type="checkbox"/> 400 mg SQ (2 injections of 200 mg) every 4 weeks <input type="checkbox"/> 200 mg SQ every 2 weeks	<input type="checkbox"/> Alt. Dosage: _____	<input type="checkbox"/> _____ boxes (2 injections) <input type="checkbox"/> 28 day supply	
<input type="checkbox"/> Humira® Pen 40mg/0.8mL	<input type="checkbox"/> Initial Dose: Week 0 (Day 1): 160mg SQ Four 40mg SQ injections on day 1 Week 2 (Day 15): 80mg (Two 40 mg injections) SQ on day 15, then maintenance dose		<input type="checkbox"/> Starter Pack (1 pack contains 6 pens)	
<input type="checkbox"/> Humira® Pre-filled Syringes 40mg/0.8ml	<input type="checkbox"/> Maintenance: (week 4+): 40 mg SQ every other week <input type="checkbox"/> Maintenance: (week 4+): 40 mg SQ every week <input type="checkbox"/> Alt. Dosage: _____	<input type="checkbox"/> Enroll in Humira Complete	<input type="checkbox"/> 28 day supply	
<input type="checkbox"/> Remicade® 100 mg vial	<input type="checkbox"/> Initial Dose: (5mg/kg): _____ mg IV on Week 0, week 2, week 6, then start maintenance dose <input type="checkbox"/> Maintenance (5mg/kg): _____ mg IV every _____ weeks for _____ infusions	<input type="checkbox"/> Enroll in AccessOne Program	<input type="checkbox"/> MD's Office Infusion	
<input type="checkbox"/> Simponi® SmartJect 100 mg/mL	<input type="checkbox"/> Starter dose: 200 mg SQ at week 0, 100 mg at week 2, then start maintenance dose at week 6		<input type="checkbox"/> QTY: _____	_____
<input type="checkbox"/> Simponi® Pre-filled Syringe 100 mg/mL	<input type="checkbox"/> Maintenance 100 mg SQ every 4 weeks starting at week 6 <input type="checkbox"/> Enroll in SimponiOne Program			
<input type="checkbox"/> Stelara™ 90mg/mL prefilled syringe	<input type="checkbox"/> 55 kg or less: 260 mg single dose IV and 90 mg/dose subcutaneously every 8 weeks <input type="checkbox"/> 56 kg to 85 kg: 390 mg single dose IV and 90 mg/dose subcutaneously every 8 weeks <input type="checkbox"/> more than 85 kg: 520 mg single dose IV and 90 mg/dose subcutaneously every 8 weeks		<input type="checkbox"/> QTY: _____	_____
<input type="checkbox"/> Methotrexate 25 mg/mL	<input type="checkbox"/> Inject _____ mg IM every week		<input type="checkbox"/> _____ mL (Doses)	
<input type="checkbox"/> Xifaxan® (Rifaximin)	<input type="checkbox"/> 550mg Tablets _____ <input type="checkbox"/> 200mg Tablets _____		Day Supply: _____	Refills: _____
<input type="checkbox"/> Other Medication:				

Physician Signature: _____ Date: _____

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In the event that 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. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265