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 ☐ Male ☐ 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
☐ **Cimzia® Prefilled Syringe** (2 Prefilled Syringe PFS of 200 mg/mL) ☐ **Cimzia® vial** (2 vials of 200 mg powder) Note: Cimzia vial should be prepared and administered by a health care professional.	☐ 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 ☐ Maintenance: ☐ 400 mg SQ (2 injections of 200 mg) every 4 weeks ☐ 200 mg SQ every 2 weeks ☐ Alt. Dosage: _____ ☐ **Enroll in Cimplicity Program**		☐ 1 kit (6 PFS) ☐ _____ boxes (2 injections) ☐ 28 day supply	
☐ **Humira® Pen 40mg/0.8mL** ☐ **Humira® Pre-filled Syringes 40mg/0.8ml**	☐ 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 ☐ Maintenance: (week 4+): 40 mg SQ every other week ☐ Maintenance: (week 4+): 40 mg SQ **every week** ☐ Alt. Dosage: _____ ☐ **Enroll in Humira Complete**		☐ Starter Pack (1 pack contains 6 pens) ☐ 28 day supply	
☐ **Remicade® 100 mg vial**	☐ Initial Dose: (5mg/kg): _____ mg IV on Week 0, week 2, week 6, then start maintenance dose ☐ Maintenance (5mg/kg): _____ mg IV every _____ weeks for _____ infusions ☐ **Enroll in AccessOne Program**		☐ MD's Office Infusion	
☐ **Simponi® SmartJect 100 mg/mL** ☐ **Simponi® Pre-filled Syringe 100 mg/mL**	☐ Starter dose: 200 mg SQ at week 0, 100 mg at week 2, then start maintenance dose at week 6 ☐ Maintenance 100 mg SQ every 4 weeks starting at week 6 ☐ **Enroll in SimponiOne Program**		☐ QTY: _____	_____
☐ **Stelara™ 90mg/mL prefilled syringe**	☐ 55 kg or less: 260 mg single dose IV and 90 mg/dose subcutaneously every 8 weeks ☐ 56 kg to 85 kg: 390 mg single dose IV and 90 mg/dose subcutaneously every 8 weeks ☐ more than 85 kg: 520 mg single dose IV and 90 mg/dose subcutaneously every 8 weeks		☐ QTY: _____	_____
☐ **Methotrexate 25 mg/mL**	☐ Inject _____ mg IM every week		☐ ____ mL (Doses)	
☐ **Xifaxan® (Rifaximin)**	☐ **550mg** Tablets _____ ☐ **200mg** Tablets _____		Day Supply: _____	Refills: _____
☐ **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.