

Patient information **Prescriber + Shipping Information**

Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ Insurance Plan: _____ Plan ID #: _____ Please fax a copy of front and back of the insurance card(s).	Physician Name: _____ NPI #: _____ Address: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to physician: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never
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Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code:

Crohn's Disease: K50.0 (Crohn's Disease of the **Small** Intenstine) K50.1 (Crohn's Disease of the **Large** Intenstine)
 K50.8 (Crohn's Disease of the **Both** Intenstines) K50.9 (Crohn's Disease, Unspecified)

Ulcerative Colitis: K51.0 (Ulcerative Pancolitis) K51.2 (Ulcerative Procolitis) K51.3 (Ulcerative Rectosigmoiditis)
 K51.5 (Left Sided Colitis) K51.8 (Other Ulcerative Colitis) K51.9 (Ulcerative Colitis, Unspecified)

Other: _____

Date of Diagnosis: _____ Date of negative TB test: _____ Any prior treatment: No Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
 Concomitant Medications: _____
 Allergies: NKDA Other: _____

Prescription

Cimzia®	Starter: <input type="checkbox"/> Inject 400 mg SQ at weeks 0, 2 and 4 Qty: <input type="checkbox"/> 1 starter kit (6 x 200mg/mL PFS) <input type="checkbox"/> 3 cartons (2 x 200mg/mL Vials/carton)	
	Maintenance: <input type="checkbox"/> Inject 400 mg SQ - every 4 weeks Qty: 1 carton (2 x 200 mg) <input type="checkbox"/> PFS <input type="checkbox"/> Vials	Refills: _____
Humira® Citrate-free (Adults)	Starter: <input type="checkbox"/> Inject 160 mg SQ -Day 1; then 80 mg on Day 15 <input type="checkbox"/> Inject 80 mg SQ - on Day 1 and Day 2; then 80 mg on Day 15 Qty: 1 starter kit (3 x 80mg/0.8mL PENS)	
	Maintenance: <input type="checkbox"/> Starting on Day 29, 40 mg SQ - every other week Qty: 1 box (2 x 40mg/0.4mL PENS)	Refills: _____
Simponi®	Starter: <input type="checkbox"/> Inject 200 mg SQ at week 0; then 100 mg at week 2 Qty: 3 box (1 x 100 mg/1 mL) <input type="checkbox"/> SmartJet™ <input type="checkbox"/> PFS	
	Maintenance: <input type="checkbox"/> Inject 100 mg SQ every 4 weeks Qty: 1 box (1 x 100 mg/1 mL) <input type="checkbox"/> SmartJet™ <input type="checkbox"/> PFS	Refills: _____
Entyvio®	Starter <input type="checkbox"/> Infuse 300 mg in 250 ml NS; IV over 30 minutes at weeks 0, 2, and 6. Maintenance: <input type="checkbox"/> Infuse 300mg in 250 ml NS IV; every 8 weeks Quantity #1 300 mg vial	Refills: _____
Stelara®	<input type="checkbox"/> Infuse 260mg IV over no less than one hour (<55kg) 2 x 130 mg/26ml Vials <input type="checkbox"/> Infuse 390mg IV over no less than one hour (>55kg) 3 x 130 mg/26ml Vials <input type="checkbox"/> Infuse 520mg IV over no less than one hour (>85kg) 4 x 130 mg/26ml Vials <input type="checkbox"/> Inject 90 mg SQ 8 weeks following initial IV dose, then every 8 weeks thereafter Date of last infusion: _____ 1 x 90mg/ml PFS	Refills: _____
Xeljanz®	<input type="checkbox"/> Take 10mg by mouth twice daily for 8 weeks 60 x 10mg tablets <input type="checkbox"/> Take 10mg by mouth twice daily 60 x 10mg tablets <input type="checkbox"/> Take 5mg by mouth twice daily 60 x 5mg tablets <input type="checkbox"/> _____	Refills: one
		Refills: _____

*Remicade and Tysabri are located on separate forms

Injection Training Provided by: Physician's Office CoxHealth at Home Other: _____

Prescriber's Signature: _____ Date: _____