MOUNTAINVIEW PHARMACY

Where we deliver care...

Fax: 770-272-9613

GI/CROHN'S/UC

Must Be Filled Out

❑ New Patient ❑ Current	Date
Patient's Name	Prescriber's Name
D.O.B. ❑ Male ❑ Female Last 4 digits of SSN	Street Address Suite #
Street Address Apt #	City State Zip
City State Zip	Phone Fax
Home Phone Cell Phone	NPI #
E-mail Address	DEA #
Bin	
PCN	
Group / ID	**In order to dispense brand, BRAND MEDICALLY NECESSARY must be handwritten:**
Does Patient have a secondary insurance? ❑ Yes ❑ No	
Allergies	
Copy of Insurance Card? ❑ Yes ❑ No	

Diagnosis/Clinical Information

Diagnosis: ICD-10:

Prescription Information

Medication	Dose / Strength	Sig	Qty	Refills
❑ Cimzia®	❑ Prefilled Syringes (2x200mg) (or) ❑ Lyophilized Vials (2x200mg)	Induction Dose: ❑ Inject 400mg SC at weeks 0, 2 and 4 Maintenance Dose: ❑ 400mg SC every 4 weeks		
❑ Entyvio®	❑ 300mg	❑ Initial: 300mg IV infusion over 30 minutes at 0, 2 and 6 weeks ❑ Maintenance: 300mg IV infusion over 30 minutes every 8 weeks		
❑ Humira® ❑ Injection training from My Humira (patient must sign below)	❑ 20mg Pen ❑ 20mg Prefilled Syringe ❑ 40mg Pen ❑ 40mg Prefilled Syringe ❑ Starter Pack	Induction Dose: ❑ Inject 160mg SC (four 40mg Pens) for first Dose (Day 1). Then Inject 80mg SC (two 40mg Pens) two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29). Maintenance Dose: ❑ Inject 40mg SC (one 40mg Pen) every other week		
❑ Remicade® Pt Weight________	❑ 100mg Vial			
❑ Simponi®	❑ 100mg SmartJect® ❑ 100mg Prefilled Syringe®	Induction Dose: ❑ Inject 200mg SC at week 0, then Inject 100mg SC at week 2, then start maintenance at week 8. Maintenance Dose: ❑ Inject 100mg SC every 4 weeks starting at week 6, after induction dose		
❑ Stelara®	❑ 260mg (2 vials) ❑ 390mg (3 vials) ❑ 520mg (4 vials) ❑ 45mgPFS	Induction Dose: ❑ Infuse ___________ intravenously over no less than 1 hour. Maintenance Dose: ❑ Inject 90mg SC every 8 weeks following initial infusion, then every 8 weeks thereafter.		
❑ Xifaxan®	❑ 200mg tabs ❑ 550mg tabs	Take __________tablets ________ times per day.		
❑ Other:				

I authorize Mountainview Pharmacy, Inc and its representative to act as my agent to initiate and execute insurance prior authorization process for this script and any future fills of the same script for the patient listed above and to sign any forms necessary on my behalf as an authorized agent. I understand I can revoke this designation at any time.

Physician Office Contact: Name:	Email:
Patient Signature:	Date:
Physician Signature:	Date:

Email: mountainview2327@att.net