INFLAMMATORY BOWEL DISEASE PRESCRIPTION ORDER FORM

PATIENT INFORMATION	PRESCRIBER INFORMATION	
Patient Name:	Prescriber Name:	Today's Date:
Date of Birth: Gender: M / F	DEA: NPI:	Need By Date:
SSN:	Address:	**Ship To:**
Address:	City, State, ZIP Code:	☐ Patient
City, State, ZIP Code:	Phone: Fax:	☐ _____
Phone:	Contact Person:	

CLINICAL INFORMATION / ICD-10 CODE

Patient Diagnosis

Primary ICD-10 Code: _____

Rationale for therapy: _____

Current Weight _____ kg/lbs Height _____ in/cm BSA _____ m²

☐ NKDA ☐ Known Drug Allergies _____

List of Current/Periously Prescribed Medications:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATION	STRENGTH	DIRECTIONS	QTY / REFILLS
☐ **Cimzia** (certolizumab pegol)	☐ 200mg prefilled syringe ☐ 200mg lyophilized power vial (healthcare provider administration only)	**Initial dose:** ☐ 400mg (given as two 200mg subcutaneous injections) at weeks 0, 2 and 4 ☐ Other: _____ **Maintenance dose:** ☐ 400mg subcutaneous injection every 4 weeks ☐ Other: _____	**Dispense:** ☐ 1 month supply ☐ 3 months supply Other: _____ Refills: _____
☐ **Humira** (adalimumab)	☐ 40mg/0.8mL prefilled syringe ☐ 40mg/0.8mL pen ☐ 20mg/0.4mL prefilled syringe	**Initial dose:** ☐ 160mg subcutaneously on day 1, then 80mg on day 15, on day 15, then 40mg every other week (per Humira starter kit) ☐ Other: _____ **Maintenance dose:** ☐ 40mg/ subcutaneous injection every other week ☐ Other: _____ Addtional directions (cyclic, one-time, duration of therapy, etc.) _____	**Dispense:** ☐ 1 month supply ☐ 3 months supply Other: _____ Refills: _____
☐ **Simponi** (golimumab)	☐ 100mg prefilled syringe syringe ☐ 100mg SmartJect auto-injector	**Initial dose:** ☐ 200mg (given as two 100mg subcutaneous injection) at week 0 ☐ 100mg subcutaneous injection at week 2 **Maintenance dose:** ☐ 100mg subcutaneous injection every 4 weeks ☐ Other: _____	**Dispense:** ☐ 1 month supply ☐ 3 months supply Other: _____ Refills: _____

PRESCRIPTION INSURANCE INFORMATION	PATIENT BILLING INFORMATION
Insurance Plan Type: Rx BIN:	Credit Card: Visa, Mastercard, American Express, Other
Processor Control No. or PCN (if available):	Credit Card Number:
Identification Number:	CVV (last 3-digits):
Rx Group:	Expiration Date (mm/yy):

CURRENT PHARMACY INFORMATION *to be contacted if we have any issues when billing insurance

Pharmacy Name:
Pharmacy Phone Number:
Pharmacy Fax Number:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Newport Lido Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

☐ **Do Not Substitute**

Prescriber Signature: _____ **Date:** _____

NEWPORT LIDO PHARMACY

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