INFLAMMATORY BOWEL DISEASE SPECIALTY CARE PROGRAM

Phone: 844-223-7510
Fax: 844-673-6161

1 PATIENT INFORMATION:

Name: ______________________
Address: ______________________
City: ______________ State: ____ Zip: ________
Phone: ______________ Alt. Phone: ______________
Email: ______________________
DOB: ________ Gender: ❍ M ❍ F Caregiver: ________
Height: ______ Weight: ______ Allergies: ____________

2 PRESCRIBER INFORMATION:

Name: ______________________
Address: ______________________
City: ______________ State: ____ Zip: ________
Phone: ______________ Fax: ______________
NPI: ______________ DEA: ______________
Office Contact: ______________ Phone: ______________
Email: ______________________

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ______________

❑ Crohn's Disease ❑ Ulcerative Colitis ❑ Irritable Bowel Syndrome

ICD-10: ______________________

Other: ______________________

Serious or active infection present? ❑ Yes ❑ No

Hep B ruled out or treatment started? ❑ Yes ❑ No

TB Test: ❑ Positive ❑ Negative Date: ______________

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ 5-ASA	______________
❑ Biologics	______________
❑ Corticosteroids	______________
❑ Immunosuppressants	______________
❑ Methotrexate	______________
❑ Surgery	______________
❑ Other	______________

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 REQUIRED INFORMATION: Front & back copies of pharmacy & medical cards along with charts & labs from last 90 days

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: ______________________ Patient's Date of Birth: ______________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ CIMZIA®	❑ Prefilled Syringe Starter Kit	❑ **Induction Dose:** Inject 400mg SC on day 1, 14 and 28	6	0
	❑ 200mg/ml Prefilled Syringe ❑ 200mg Lyophilized Powder	❑ **Maintenance:** Inject 400mg SC every 4 weeks ❑ ______________	2	
❑ HUMIRA®	❑ Crohn's Disease/Ulcerative Colitis Starter Kit ❑ 80mg/0.8ml Pen	❑ **Induction Dose:** ❑ Inject two 80mg Pens SC on day 1, then one 80mg Pen SC on day 15 ❑ Inject one 80mg Pen SC on day 1, then 80mg Pen SC on day 2, then one 80mg Pen SC on day 15	3	0
	❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ **Maintenance:** Inject 40mg SC every other week ❑ ______________ ❑ *Patient has signed HUMIRA Complete form*	2	
	All strengths and dosages listed are Humira® Citrate Free			
❑ SIMPONI®	❑ 100mg/ml Smartject® Autoinjector	❑ **Induction Dose:** Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose	3	0
	❑ 100mg/ml Prefilled Syringe	❑ **Maintenance:** Inject 100mg SC every 4 weeks	1	
❑ STELARA®	❑ 130mg/26ml Vial	❑ **Induction Dose:** Patient Weight <55kg: 260mg; >55kg to 85kg: 390mg; >85 kg: 520mg administered IV		0
	❑ 45mg/0.5ml Prefilled Syringe ❑ 90mg/ml Prefilled Syringe ❑ 45mg/0.5ml Vial	❑ **Maintenance Dose:** Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	1	
❑ UCERIS®	❑ 9mg Tablets	❑ Take one tablet daily in the morning with or without food	30	1
❑ XELJANZ®	❑ 5mg Tablets ❑ 10mg Tablets	❑ **Induction Dose:** Take 10mg orally twice daily for 8 weeks ❑ **Maintenance Dose:** Take 5mg orally twice daily ❑ **Maintenance Dose:** Take 10mg orally twice daily ❑ ______________ *Severe renal or moderate hepatic impairment: half the total daily dosage recommended for patients with normal renal and hepatic function*		
❑ XIFAXAN®	❑ 550mg Tablets	❑ Take one tablet three times daily for 14 days	42	
❑ ________	________	________		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______________ Date: ________ Signature: ______________ Date: ________

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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