

1 PATIENT INFORMATION

Patient's Name _____
 Date of Birth _____ Male Female Last 4 digits of SSN _____
 Street Address _____ Apt# _____
 City _____ State _____ Zip _____
 Parent/Guardian (if applicable) _____
 Home Phone _____ Work Phone _____
 Cell Phone _____ Evening Phone _____
 E-mail address _____
 Insurance Company Name _____
 Insurance Company Phone No. _____
 Insured's Name _____
 Relationship to Patient _____
 Identification No. _____ Policy/Group No. _____
 Prescription Card No Yes If Yes, Carrier _____
 Policy No. _____ Group No. _____
 Is patient eligible for Medicare? No Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name _____
 Office Contact _____ Office hours: _____
 Clinic / Hospital Affiliation _____
 Street Address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI No. _____ License No. _____
 DEA No. _____
 Physician Medicaid UPIN No. _____
MD Specialty _____

To reach your team, call toll-free 1 866 489-1899.
Please fax completed form to the Crohn's team
1 866 489-1901.

3 CLINICAL INFORMATION

ICD9 CODE _____
 Current Weight _____ kg _____ lbs Height _____ inches/cm BSA _____ m²
Rx:
 Cimzia[®]
 Initial dose of 400 mg SC at week 0, week 2, and week 4 followed by:
 Maintenance dose of 400 mg SC every 4 weeks
 Other: _____
 Humira[®]
Initial Dose:
 Inject 160 mg subcutaneously on day 1, 80 mg on day 15, then 40 mg every other week. (Per Humira starter kit)
Maintenance Dose:
 Inject 40 mg subcutaneously every other week.
 Humira 40 mg/ 0.8mL PFS Humira 40 mg/ 0.8mLPens
 Remicade[®]
 Infuse Remicade in NS 250 mL over 2 hours as directed
 5 mg per kg 3 mg per kg @ 0,2 & 6 weeks 3 mg per kg every 8 weeks
SIG: Dose: _____

Directions (Include daily, weekly, cyclic, one-time, duration of therapy, etc.)

Quantity: _____ Refills: _____

NKDA Known Drug Allergies: _____

EXPECTED DATE OF FIRST/NEXT DOSE: _____ Date of Last Dose? _____

Deliver product to: Office Patient's Home Clinic
 Clinic Location _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name _____

Prescriber's Signature (sign below) _____ **Date** _____

Dispense as Written

Substitution Allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)