Crohn's Disease
Ulcerative Colitis

Rx International Pharmacy

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Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑kg ❑lbs Ht:_____❑cm ❑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).

Prescriber + Shipping Information

Physician Name:_____
NPI #: _____
Address: _____
City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to physician: ❑ 1st Fill ❑ Always ❑ Never

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: ❑ Inject 400 mg Sub-Q at weeks 0, 2 and 4
Qty: ❑ 1 starter kit (6 x 200mg/mL PFS) ❑ 3 cartons (2 x 200mg/mL Vials/carton)

Maintenance: ❑ Inject 400 mg Sub-Q every 4 weeks ❑ Inject 200 mg SQ every 2 weeks
Qty: 1 carton (2 x 200 mg) ❑ PFS ❑ Vials Refills: _____

❑ Humira® (Adults)

Starter: ❑ Inject 160 mg Sub-Q Day 1; then 80 mg on Day 15
❑ Inject 80 mg Sub-Q on Day 1 and Day 2; then 80 mg on Day 15
Qty: ❑ 1 carton (6x40 mg/0.8mL Pens) ❑ 1 carton (6x40 mg/0.8mL PFS)

Maintenance: ❑ Starting on Day 29, 40 mg Sub-Q every other week
Qty: ❑ 1 carton (2 x 40 mg/0.8mL Pens) ❑ 1 carton (2 x 40 mg/0.8mL PFS) Refills: _____

❑ Humira® (Pediatrics ≥ 6 years)

Starter: ❑ Inject 80 mg Sub-Q Day 1; then 40 mg on Day 15 (17 to <40 kg)
❑ Inject 80 mg Sub-Q on Day 1 and Day 2; then 80 mg on Day 15 (≥40 kg)
❑ Inject 160 mg Sub-Q Day 1; then 80 mg on Day 15 (≥40 kg)
Qty: ❑ 1 carton (3x40 mg/0.8mL PFS) ❑ 1 carton (6x40 mg/0.8mL Pens) ❑ 1 carton (6x40 mg/0.8mL PFS)

Maintenance: ❑ Starting on Day 29, 20 mg Sub-Q every other week (17 to <40 kg)
❑ Starting on Day 29, 40 mg Sub-Q every other week (≥40 kg)
Qty: ❑ 1 carton (2 x 20 mg/0.8mL PFS)
❑ 1 carton (2 x 40 mg/0.4mL Pens) ❑ 1 carton (2 x 40 mg/0.8mL PFS) Refills: _____

❑ Simponi®

Starter: ❑ Inject 200 mg Sub-Q at week 0; then 100 mg at week 2
Qty: 3 box (1 x 100 mg/0.5 mL) ❑ SmartJet™ ❑ PFS

Maintenance: ❑ Inject 100 mg Sub-Q every 4 weeks
Qty: 1 box (1 x 100 mg/0.5 mL) ❑ SmartJet™ ❑ PFS Refills: _____

❑ _____

Strength: _____ Qty: _____
Directions: _____ Refills: _____

Injection Training Provided by: ❑ Physician's Office ❑ Pharmacy ❑ Other: _____

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature:_____ Date: _____
I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.