



Patient information **Prescriber + Shipping Information**

Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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).	Physician Name: _____ NPI #: _____ Address: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to physician: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never
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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

<input type="checkbox"/> Cimzia®	Starter: <input type="checkbox"/> Inject 400 mg Sub-Q at weeks 0, 2 and 4 Qty: <input type="checkbox"/> 1 starter kit (6 x 200mg/mL PFS) <input type="checkbox"/> 3 cartons (2 x 200mg/mL Vials/carton) Maintenance: <input type="checkbox"/> Inject 400 mg Sub-Q every 4 weeks <input type="checkbox"/> Inject 200 mg SQ every 2 weeks Qty: 1 carton (2 x 200 mg) <input type="checkbox"/> PFS <input type="checkbox"/> Vials Refills: _____
<input type="checkbox"/> Humira® (Adults)	Starter: <input type="checkbox"/> Inject 160 mg Sub-Q Day 1; then 80 mg on Day 15 <input type="checkbox"/> Inject 80 mg Sub-Q on Day 1 and Day 2; then 80 mg on Day 15 Qty: <input type="checkbox"/> 1 carton (6x40 mg/0.8mL Pens) <input type="checkbox"/> 1 carton (6x40 mg/0.8mL PFS) Maintenance: <input type="checkbox"/> Starting on Day 29, 40 mg Sub-Q every other week Qty: <input type="checkbox"/> 1 carton (2 x 40 mg/0.8mL Pens) <input type="checkbox"/> 1 carton (2 x 40 mg/0.8mL PFS) Refills: _____
<input type="checkbox"/> Humira® (Pediatrics ≥ 6 years)	Starter: <input type="checkbox"/> Inject 80 mg Sub-Q Day 1; then 40 mg on Day 15 (17 to <40 kg) <input type="checkbox"/> Inject 80 mg Sub-Q on Day 1 and Day 2; then 80 mg on Day 15 (≥40 kg) <input type="checkbox"/> Inject 160 mg Sub-Q Day 1; then 80 mg on Day 15 (≥40 kg) Qty: <input type="checkbox"/> 1 carton (3x40 mg/0.8mL PFS) <input type="checkbox"/> 1 carton (6x40 mg/0.8mL Pens) <input type="checkbox"/> 1 carton (6x40 mg/0.8mL PFS) Maintenance: <input type="checkbox"/> Starting on Day 29, 20 mg Sub-Q every other week (17 to <40 kg) <input type="checkbox"/> Starting on Day 29, 40 mg Sub-Q every other week (≥40 kg) Qty: <input type="checkbox"/> 1 carton (2 x 20 mg/0.8mL PFS) <input type="checkbox"/> 1 carton (2 x 40 mg/0.4mL Pens) <input type="checkbox"/> 1 carton (2 x 40 mg/0.8mL PFS) Refills: _____
<input type="checkbox"/> Simponi®	Starter: <input type="checkbox"/> Inject 200 mg Sub-Q at week 0; then 100 mg at week 2 Qty: 3 box (1 x 100 mg/0.5 mL) <input type="checkbox"/> SmartJet™ <input type="checkbox"/> PFS Maintenance: <input type="checkbox"/> Inject 100 mg Sub-Q every 4 weeks Qty: 1 box (1 x 100 mg/0.5 mL) <input type="checkbox"/> SmartJet™ <input type="checkbox"/> PFS Refills: _____
<input type="checkbox"/> _____	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.

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