

Patient Information

Patient Name: _____ DOB: _____ Sex: Male Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____
 Address: _____ Phone: _____ Alternate: _____
 Caregiver Name: _____ Relation to Patient: _____ Phone: _____
 Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____
 Address: _____
 Phone: _____ Alternate: _____ Fax: _____ Email: _____
 If shipping to prescriber: First Fill Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Crohn's Disease: K50.0 (Crohn's Disease of the Small Intestine) K50.1 (Crohn's Disease of the Large Intestine)
 K50.8 (Crohn's Disease of Both Intestines) 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: _____
 Diagnosis Date: _____ TB Test: Yes No Neg. Test Date: _____

Prior Therapy Yes No _____
 Reason for Discontinuation of Therapy _____
 Approximate Start Date _____ Approximate End Date _____
 Comorbidities: _____
 Concomitant Medications: _____
 Allergies: NKDA Other: _____

Prescription	Directions	Quantity	Form	Refills
<input type="checkbox"/> Cimzia® (certolizumab)	<input type="checkbox"/> Inject 400 mg subq at weeks 0, 2 and 4 <input type="checkbox"/> Inject 400 mg subq every 4 weeks	<input type="checkbox"/> 6 x 200 mg/mL <input type="checkbox"/> 2 x 200 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	0
<input type="checkbox"/> Humira® (adalimumab) <i>Adults</i>	<input type="checkbox"/> Inject 160 mg subq on day 1, then 80 mg on day 15 <input type="checkbox"/> Inject 40 mg subq on day 29 and every other week thereafter	<input type="checkbox"/> 6 x 40 mg/0.8mL <input type="checkbox"/> 2 x 40 mg/0.8mL	<input type="checkbox"/> Pens <input type="checkbox"/> PFS	0
<input type="checkbox"/> Entyvio® (vedolizumab)	<input type="checkbox"/> Infuse 300mg intravenously at weeks 0 and 2 <input type="checkbox"/> Infuse 300mg intravenously at week 6 then every 8 weeks thereafter	<input type="checkbox"/> 2 x 300mg <input type="checkbox"/> 1 x 300mg	<input type="checkbox"/> Vials	0
<input type="checkbox"/> Humira® (adalimumab) <i>Pediatrics ≥ 6 years</i>	<input type="checkbox"/> Inject 80 mg subq day 1, then 40 mg on day 15 (17 to <40 kg) <input type="checkbox"/> Inject 160 mg subq day 1, then 80 mg on day 15 (≥40 kg) <input type="checkbox"/> Inject 20 mg subq on day 29 and every other week thereafter (17 to <40 kg) <input type="checkbox"/> Inject 40 mg subq on day 29 and every other week thereafter (≥40 kg)	<input type="checkbox"/> 3 x 40 mg/0.8mL <input type="checkbox"/> 6 x 40 mg/0.8mL <input type="checkbox"/> 2 x 20 mg/0.4mL <input type="checkbox"/> 2 x 40 mg/0.8mL	<input type="checkbox"/> Pens <input type="checkbox"/> PFS	0
<input type="checkbox"/> Inflectra® (infliximab) <input type="checkbox"/> Renflexis® (infliximab)	<input type="checkbox"/> Infuse 5mg/kg at weeks 0 and 2 <input type="checkbox"/> Infuse 5mg/kg at week 6 and then every 8 weeks thereafter	<input type="checkbox"/> 100mg	<input type="checkbox"/> Vials	0
<input type="checkbox"/> Remicade® (infliximab)	<input type="checkbox"/> Infuse 5mg/kg at weeks 0 and 2 <input type="checkbox"/> Infuse 5mg/kg at week 6 and then every 8 weeks thereafter	<input type="checkbox"/> 100mg	<input type="checkbox"/> Vials	0
<input type="checkbox"/> Simponi® (golimumab)	<input type="checkbox"/> Inject 200 mg subq at week 0, then 100 mg at week 2 <input type="checkbox"/> Inject 100 mg subq every 4 weeks	<input type="checkbox"/> 3 x 100 mg/mL <input type="checkbox"/> 1 x 100 mg/mL	<input type="checkbox"/> SmartJect® Autoinjector <input type="checkbox"/> PFS <input type="checkbox"/> SmartJect® Autoinjector <input type="checkbox"/> PFS	0
<input type="checkbox"/> Stelara® (ustekinumab)	<input type="checkbox"/> Infuse 260 mg intravenously over no less than one hour (≤55kg) <input type="checkbox"/> Infuse 390 mg intravenously over no less than one hour (>55 kg to <85 kg) <input type="checkbox"/> Infuse 520 mg intravenously over no less than one hour (>85 kg) <input type="checkbox"/> Inject 90 mg subq 8 weeks following initial intravenous dose, then every 8 weeks thereafter Patient eligible for self-administration? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last infusion: _____	<input type="checkbox"/> 2 x 130 mg/26 mL <input type="checkbox"/> 3 x 130 mg/26 mL <input type="checkbox"/> 4 x 130 mg/26mL <input type="checkbox"/> 1 x 90 mg/mL	<input type="checkbox"/> Vials <input type="checkbox"/> PFS	0
<input type="checkbox"/> Tysarbi® (natalizumab)	<input type="checkbox"/> Infuse 300mg intravenously over 1 hour every 4 week	<input type="checkbox"/> 1 x 300mg	<input type="checkbox"/> Vials	
<input type="checkbox"/> Xifaxan® (rifaximin)	<input type="checkbox"/> Irritable Bowel Syndrome with Diarrhea: Take one tablet by mouth 3 times a day for 14 days <input type="checkbox"/> Hepatic Encephalopathy: Take one tablet by mouth 2 times a day	<input type="checkbox"/> 42 x 550mg <input type="checkbox"/> 60 x 550mg	<input type="checkbox"/> Tablets <input type="checkbox"/> Tablets	

Injection training provided by: Physician's Office Pharmacy Other: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

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