



PATIENT INFORMATION

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:		Allergies:				
City:	State:	Zip:	Home Phone: ()	Work or Cell: ()		
HIPAA Contact:		Emergency #: ()			Interpreter Needed: <input type="radio"/> Y <input type="radio"/> N	

PRESCRIBER INFORMATION

Prescriber Name:	<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA	NPI:
Office Contact:	Supervising Physician, if applicable:	
Address:		City: State: Zip:
Phone:	Fax:	

INSURANCE INFORMATION | PLEASE SEND COPY OF INSURANCE CARD

Primary Insurance:	Policy ID:	Group #:
Policyholder Name:	Policyholder DOB: / /	BIN: PCN:

CLINICAL INFORMATION | PLEASE SEND COPY OF PROGRESS NOTES AND LAB REPORTS SUPPORTING DIAGNOSIS

ICD- ICD-10/Diagnosis Code:	Crohn's Disease: <input type="radio"/> K50.0__ (Crohn's of the Small Intestine) <input type="radio"/> K50.1__ (Crohn's of the Large Intestine) <input type="radio"/> K50.8__ (Crohn's of Both Intestines) <input type="radio"/> K50.9__ (Crohn's, Unspecif		
Ulcerative Colitis:	<input type="radio"/> K51.0__ (Ulcerative Pancolitis) <input type="radio"/> K51.2__ (Ulcerative Procolitis) <input type="radio"/> K51.3__ (Ulcerative Rectosigmoiditis) <input type="radio"/> K51.5__ (Left Sided Colitis) <input type="radio"/> K51.8__ (Other Ulcerative Colitis)		
	<input type="radio"/> K51.9__ (Ulcerative Colitis, Unspecified) <input type="radio"/> K58.0__ (Irritable Bowel Syndrome with Diarrhea) <input type="radio"/> Other: _____		
Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment: <input type="radio"/> Yes <input type="radio"/> No (provide information below)	
Prior Therapy:		Reason for Discontinuation of Therapy:	

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Sig	Quantity	Refills
<input type="radio"/> CANASA®	<input type="radio"/> Box of 30 <input type="radio"/> Box of 42	<input type="radio"/> 1000mg rectal suppository inserted rectally once daily at bedtime		
<input type="radio"/> CIMZIA® <input type="radio"/> PFS <input type="radio"/> Vial	<input type="radio"/> Prefilled Syringe Starter Kit (6x200mg/ml) <input type="radio"/> 400mg (2x200mg/ml)	<input type="radio"/> <u>Starter Dose:</u> Inject 400mg SQ at weeks 0, 2, and 4 <input type="radio"/> <u>Maintenance Dose:</u> Inject 400mg SQ every 4 weeks <input type="radio"/> <u>Maintenance Dose:</u> Inject 200mg SQ every 2 weeks	28 Day Supply	
<input type="radio"/> ENTYVIO®	<input type="radio"/> 300mg in 20ml Vial	<input type="radio"/> Infuse over 30 minutes at 0, 2, 6 weeks, then every 8 weeks	QS for Infusion	
<input type="radio"/> HUMIRA® PEN <input type="radio"/> Pen <input type="radio"/> PFS	<input type="radio"/> Crohn's & U.C. Starter Kit 160mg (6 Pens) <input type="radio"/> Maintenance: 40mg (2 Pen) <input type="radio"/> Other: _____	<input type="radio"/> <u>Starter Dose:</u> Inject 4 Pens (160mg) SQ on day 1, then 80mg (2 Pens) on day 15 then on day 29 begin maintenance dosing <input type="radio"/> <u>Maintenance Dose:</u> Inject 1 Pen (40mg) SQ every 14 days	28 Day Supply	
<input type="radio"/> RELISTOR® <input type="radio"/> PFS <input type="radio"/> Vial	<input type="radio"/> 8mg (Qty 7) <input type="radio"/> 12mg (Qty 7) <input type="radio"/> 12mg (Qty 1)	<input type="radio"/> Inject 12mg SQ once daily <input type="radio"/> Inject _____ mg SQ every other day	28 Day Supply	
<input type="radio"/> REMICADE®	<input type="radio"/> Exact Dose <input type="radio"/> Round dose up/down to nearest 100mg	<input type="radio"/> Infuse _____ mg in 250NS over 2hrs at week 0, 2, 6 and then every 8 weeks. <input type="radio"/> Other Regimen: <i>*Titrated infusion rate will be used unless otherwise noted: 10 ml/hr x 15min; 20ml/hr x 15min; 40ml/hr x 15min; 80ml/hr x 15min; 150ml/hr x 30 min</i>	QS for Infusion	
<input type="radio"/> SIMPONI® <input type="radio"/> SmartJect <input type="radio"/> PFS	<input type="radio"/> 100mg/ml (Qty 3 Box) <input type="radio"/> 100mg/ml (Qty 1 Box)	<input type="radio"/> <u>Starter Dose:</u> Inject 200mg SQ at week 0; then 100 mg at week 2 <input type="radio"/> <u>Maintenance Dose:</u> Inject 100 mg SQ every 4 weeks	28 Day Supply	
<input type="radio"/> STELARA®	<input type="radio"/> 55kg or less 260mg 2 Vials <input type="radio"/> > 55kg to 85kg 390mg 3 Vials <input type="radio"/> > 85kg 520mg 4 Vials <input type="radio"/> 45mg/0.5ml PFS (Qty 1) <input type="radio"/> 90mg/ml PFS (Qty 1)	<input type="radio"/> <u>Starter Dose:</u> <input type="radio"/> Infuse _____ mg IV over at least one hour <input type="radio"/> <u>Maintenance Dose:</u> <input type="radio"/> Inject 0.5ml (45mg) SQ 8 weeks after infusion, then every 8 weeks thereafter <input type="radio"/> Inject 1ml (90mg) SQ 8 weeks after infusion, then every 8 weeks thereafter	QS for Infusion	
<input type="radio"/> UCERIS®	<input type="radio"/> 9mg Tab	<input type="radio"/> Take once daily by mouth for up to 8 weeks	30 Day Supply	
<input type="radio"/> UCERIS® RECTAL FOAM	<input type="radio"/> 2mg (14 doses/package) <input type="radio"/>	<input type="radio"/> Administer 1 metered dose (2mg) rectally twice daily for 2 weeks, then 1 metered dose (2mg) rectally once daily for 4 weeks.	28 Day Supply	
<input type="radio"/> XIFAXAN®	<input type="radio"/> 200mg Tab <input type="radio"/> 550mg Tab	<input type="radio"/> Take 1 tablet by mouth 3 times a day for _____ days		
<input type="radio"/> Other:	<input type="radio"/>	<input type="radio"/>		

Additional Instructions:

INJECTION TRAINING

Patient received injection training Prescriber's office to provide injection training Price Chopper Specialty to coordinate injection training

By signing this form and utilizing our services, you are authorizing Price Chopper Specialty to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature:	Date Issued: / /
Substitution Permitted	

Prescriber Signature:	Date Issued: / /
Dispense as Written	

Interchange is mandated unless the practitioner indicates 'Dispense as Written' or 'No Substitution' in accordance with the law.