Crohn's Disease
Ulcerative Colitis (drugs A-R)

(Cimzia®, Humira®)

Patient Information

Patient name: ________________________ DOB: _____________
Sex: ❑ Female ❑ Male SSN: ______________________________
Language: ____________ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in
Address: ____
Apt/Suite: _____ City: ________________ State: _____ Zip: ______
Phone: ___________________ Alternate: ____________________
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

Prescriber name: ____
NPI: ____
Address: ____
Apt/Suite: ______ City: ____________ State: _______ Zip: ______
Contact: ____
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** Intenstine) ❑ K50.1 (Crohn's Disease of the **Large** Intenstine) ❑ K50.8 (Crohn's Disease of **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: ❑ ________________________________

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

Drug	Directions	Quantity	Form	Refills
❑ **Cimzia®** **(certolizumab)**	❑ Inject 400 mg subcut at weeks 0, 2 and 4	❑ 6 x 200 mg/mL	❑ PFS ❑ Vials	0
	❑ Inject 400 mg subcut every 4 weeks	❑ 2 x 200 mg/mL	❑ PFS ❑ Vials	_____
❑ **Humira®** **(adalimumab)** *Adults*	❑ Inject 160 mg subcut on day 1, then 80 mg on day 15 ❑ ________________________	❑ 6 x 40 mg/0.8mL	❑ Pens ❑ PFS	0
	❑ Inject 40 mg subcut on day 29 and every other week thereafter	❑ 2 x 40 mg/0.8mL	❑ Pens ❑ PFS	_____
❑ **Humira®** **(adalimumab)** *Pediatrics ≥ 6 years*	❑ Inject 80 mg subcut day 1, then 40 mg on day 15 (17 to <40 kg) ❑ Inject 160 mg subcut day 1, then 80 mg on day 15 (≥40 kg) ❑ ________________________	❑ 3 x 40 mg/0.8mL ❑ 6 x 40 mg/0.8mL	❑ Pens ❑ PFS	0
	❑ Inject 20 mg subcut on day 29 and every other week thereafter (17 to <40 kg)	❑ 2 x 20 mg/0.4mL	PFS	_____
	❑ Inject 40 mg subcut on day 29 and every other week thereafter (≥40 kg)	❑ 2 x 40 mg/0.8mL	❑ Pens ❑ PFS	

§ Simponi® and Stelara® are available on the Crohn's Disease/Ulcerative Colitis Enrollment Form S-Z §

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

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

Stamp signature not allowed, physician signature required.

Prescriber's Signature:_______________________________________ Date: ______________

I authorize Diplomat Pharmacy, Inc. 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 Diplomat Pharmacy, Inc.

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