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

(Cimzia®, Humira®)

DIPLOMAT®

--Select One--
Phone
Fax
Insert Sales Contact Name (if known)

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: _____

Has the patient received their starter dose(s)/kit? ☐ Yes; Start Date: _____ ☐ No

Prescription

☐ **Cimzia®** **(certolizumab)**	☐ Inject 400 mg subcut at weeks 0, 2 and 4	☐ 6 x 200 mg/mL	P☐ V☐	0
	☐ Inject 400 mg subcut every 4 weeks	☐ 2 x 200 mg/mL	P☐ V☐	_____
☐ **Humira®** **(adalimumab)** *Adults*	☐ Inject 160 mg subcut on day 1, then 80 mg on day 15	☐ 6 x 40 mg/0.4 mL	Citrate Free PFS☐ Starter☐ Kit Pens	0
		☐ 6 x 40 mg/0.8 mL	P☐ ☐ Starter Kit Pens	
	☐ _____	☐ 3 x 80 mg/0.8 mL	C☐ te Free Starter Kit Pens	
	☐ Inject 80 mg subcut on day 29 and every other week thereafter	☐ 2 x 40 mg/0.4 mL	Citrate Free PF☐ P☐s	_____
		☐ 2 x 40 mg/0.8mL	P☐ Pens☐	
☐ **Humira®** **(adalimumab)** *Pediatrics ≥ 6 years*	☐ Starter dose: Inject 80 mg subcut day 1, then 40 mg on day 15 (17 to <40 kg)	☐ 1 x 80 mg/0.8 mL+ 1 x 40 mg/0.4 mL	Citrate Free Starter Kit PFS	0
		☐ 3 x 40 mg/0.8 mL	Starter Kit PFS	
	☐ Starter dose: Inject 160 mg subcut day 1, then 80 mg on day 15 (≥40 kg)	☐ 6 x 40 mg/0.8 mL	Starter Kit PFS	
		☐ 3 x 80 mg/0.8 mL	Citrate Free Starter Kit PFS	
	☐ Maintenance: Inject 20 mg subcut on day 29 and every other week thereafter (17 to <40 kg)	☐ 2 x 20 mg/0.2 mL	Citrate Free PFS	_____
		☐ 2 x 20 mg/0.4mL	PFS	
	☐ Maintenance: Inject 40 mg subcut on day 29 and every other week thereafter (≥40 kg)	☐ 2 x 40 mg/0.4mL	Citrate Free ☐ PFS ☐ Pens	
		☐ 2 x 40 mg/0.8mL	P☐s Pens ☐	

§ Simponi®, Stelara® and Xeljanz® 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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