

Crohn's Disease

Ulcerative Colitis (drugs A-R)



(Cimzia®, Humira®)

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

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

Clinical Information (Please fax all pertinent clinical and lab information)			
Crohn's Disease: <input type="checkbox"/> K50.0 (Crohn's Disease of the Small Intestine) <input type="checkbox"/> K50.1 (Crohn's Disease of the Large Intestine) <input type="checkbox"/> K50.8 (Crohn's Disease of Both Intestines) <input type="checkbox"/> K50.9 (Crohn's Disease, unspecified)			
Ulcerative Colitis: <input type="checkbox"/> K51.0 (Ulcerative Pancolitis) <input type="checkbox"/> K51.2 (Ulcerative Procolitis) <input type="checkbox"/> K51.3 (Ulcerative Rectosigmoiditis) <input type="checkbox"/> K51.5 (Left Sided Colitis) <input type="checkbox"/> K51.8 (Other Ulcerative Colitis) <input type="checkbox"/> K51.9 (Ulcerative Colitis, unspecified)			
Other: <input type="checkbox"/> _____			
Diagnosis Date: _____ TB Test: <input type="checkbox"/> Yes <input type="checkbox"/> No Neg. Test Date: _____			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			
Has the patient received their starter dose(s)/kit? Yes; Start Date: _____ No			

Prescription					
<input type="checkbox"/> 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	<input type="checkbox"/> 2 x 200 mg/mL	PFS Vials		
<input type="checkbox"/> Humira® (adalimumab) <i>Adults</i>	Inject 160 mg 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	PFS Starter Kit Pens		
	_____	3 x 80 mg/0.8 mL	Citrate Free Starter Kit Pens		
<input type="checkbox"/> Humira® (adalimumab) <i>Pediatrics ≥ 6 years</i>	Inject 40 mg subcut on day 1 and every other week thereafter	2 x 40 mg/0.4 mL	Citrate Free PFS Pens	0	
	_____	2 x 40 mg/0.8mL	PFS Pens		
	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		
	_____	3 x 40 mg/0.8 mL	Starter Kit PFS		
<input type="checkbox"/> Humira® (adalimumab) <i>Pediatrics ≥ 6 years</i>	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		
<input type="checkbox"/> Humira® (adalimumab) <i>Pediatrics ≥ 6 years</i>	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	PFS 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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