

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

(Cimzia®, Humira®)



toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information		Prescriber + Shipping Information			
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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 name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never			
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: _____					
Prescription					
<input type="checkbox"/> Cimzia® (certolizumab)	<input type="checkbox"/> Inject 400 mg subcut at weeks 0, 2 and 4	<input type="checkbox"/> 6 x 200 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	0	
	<input type="checkbox"/> Inject 400 mg subcut every 4 weeks	<input type="checkbox"/> 2 x 200 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	_____	
<input type="checkbox"/> Humira® (adalimumab) <i>Adults</i>	<input type="checkbox"/> Inject 160 mg subcut on day 1, then 80 mg on day 15	<input type="checkbox"/> 6 x 40 mg/0.8mL	<input type="checkbox"/> Pens <input type="checkbox"/> PFS	0	
	<input type="checkbox"/> _____ <input type="checkbox"/> Inject 40 mg subcut on day 29 and every other week thereafter	<input type="checkbox"/> 2 x 40 mg/0.8mL	<input type="checkbox"/> Pens <input type="checkbox"/> PFS	_____	
<input type="checkbox"/> Humira® (adalimumab) <i>Pediatrics ≥ 6 years</i>	<input type="checkbox"/> Inject 80 mg subcut day 1, then 40 mg on day 15 (17 to <40 kg)	<input type="checkbox"/> 3 x 40 mg/0.8mL <input type="checkbox"/> 6 x 40 mg/0.8mL	<input type="checkbox"/> Pens <input type="checkbox"/> PFS	0	
	<input type="checkbox"/> Inject 160 mg subcut day 1, then 80 mg on day 15 (≥40 kg)				
	<input type="checkbox"/> _____	<input type="checkbox"/> 2 x 20 mg/0.4mL	PFS	_____	
	<input type="checkbox"/> Inject 20 mg subcut on day 29 and every other week thereafter (17 to <40 kg)	<input type="checkbox"/> 2 x 40 mg/0.8mL	<input type="checkbox"/> Pens <input type="checkbox"/> PFS		
§ Simponi® and Stelara® are available on the Crohn's Disease/Ulcerative Colitis Enrollment Form S-Z §					
Injection Training Provided by: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Pharmacy <input type="checkbox"/> 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: _____ <small>I authorize Thrifty White Specialty Pharmacy 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 Thrifty White Specialty Pharmacy.</small>					

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www.thriftywhite.com

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