

Crohn's Disease Ulcerative Colitis (drugs S-Z)

(Simponi®, Stelara®)



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				
§ Cimzia® and Humira® are available on the Crohn's Disease/Ulcerative Colitis Enrollment Form A-R §				
<input type="checkbox"/> Simponi® (golimumab)	<input type="checkbox"/> Inject 200 mg subcut at week 0, then 100 mg at week 2	<input type="checkbox"/> 3 x 100 mg/mL	<input type="checkbox"/> SmartJect® Autoinjector <input type="checkbox"/> PFS	0
	<input type="checkbox"/> Inject 100 mg subcut every 4 weeks	<input type="checkbox"/> 1 x 100 mg/mL	<input type="checkbox"/> SmartJect® Autoinjector <input type="checkbox"/> PFS	_____
<input type="checkbox"/> Stelara® (ustekinumab)	<input type="checkbox"/> Infuse 260 mg intravenously over no less than one hour (≤55kg)	<input type="checkbox"/> 2 x 130 mg/26 mL	<input type="checkbox"/> Vials	0
	<input type="checkbox"/> Infuse 390 mg intravenously over no less than one hour (>55 kg to <85 kg)	<input type="checkbox"/> 3 x 130 mg/26 mL		
	<input type="checkbox"/> Infuse 520 mg intravenously over no less than one hour (>85 kg)	<input type="checkbox"/> 4 x 130 mg/26mL		
	<input type="checkbox"/> Inject 90 mg subcut 8 weeks following initial intravenous dose, then every 8 weeks thereafter	<input type="checkbox"/> 1 x 90 mg/mL	<input type="checkbox"/> PFS	_____
Patient eligible for self-administration: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of last infusion: _____				
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: _____				
<i>Stamp signature not allowed, physician signature required.</i>				
Prescriber's Signature: _____				Date: _____
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.				

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www.thriftywhite.com

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