CROHN'S DISEASE & ULCERATIVE COLITIS AGENTS

PHONE: 888-903-7453 • FAX: 888-958-2831 • www.praxisrx.com

PATIENT INFORMATION

Patient:______________________________ Caregiver: ______________________________
DOB:____________________ ☐ Male or ☐ Female Weight:________ ☐ kgs or ☐ lbs (check one) Allergies:____________________
Address:______________________________ City:____________________ State:__________ Zip:______________
Primary Phone #:______________________ ☐ Cell Alternate Phone #:______________________ ☐ Cell
Email:______________________________

CLINICAL INFORMATION

ICD-10 Code: Crohn's disease: ☐K50.0 ☐K50.1 ☐K50.8 ☐K50.9
Ulcerative colitis: ☐K51.0 ☐K51.2 ☐K51.3 ☐K51.5 ☐K51.8 ☐K51.9

Does the patient have a Negative TB test result? ☐Yes ☐No Date of Test: ____________________

Please provide clinical rationale for prescribing this agent:

Prior therapies: ______________________ Reason for discontinuation: ____________________

Therapy: ☐ New ☐ Reauthorization Other: ______________________________

PRESCRIPTION INFORMATION

Drug	Product	Dose	Quantity	Refills
Cimzia®	☐ Cimzia Starter Kit (Prefilled Syringes) ☐ 200mg Lyophilized Vials (LYO)	**Induction Dose:** ☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200mg/mL PFS ☐ 3 Cartons = 6 x 200mg Vials (LYO)	Refills: _______
	☐ 200mg/mL Prefilled Syringes ☐ 200mg Lyophilized Vials (LYO)	**Maintenance Dose:** ☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200mg/mL PFS ☐ 1 Carton = 2 x 200mg Vials (LYO)	Refills: _______
Humira®	☐ Humira Induction Dose ☐ Pens ☐ Prefilled Syringes (PFS)	**Induction Dose:** ☐ 160mg Sub-Q Day 1, 80mg Day 15, 40mg Day 29 and every other week thereafter	☐ 1 Kit = 6 x 40mg Pens ☐ 3 Cartons = 6 x 40mg PFS	Refills: _______
	☐ 40mg Pens ☐ 40mg Prefilled Syringes (PFS)	**Maintenance Dose:** ☐ 40mg Sub-Q every other week ☐ 40mg Sub-Q once weekly	☐ 1 Carton = 2 x 40mg Pens ☐ 1 Carton = 2 x 40mg PFS ☐ 2 Cartons = 4 x 40mg Pens ☐ 2 Cartons = 4 x 40mg PFS	Refills: _______
Remicade®	☐ 100mg Lyophilized Vials (LYO)	**Induction Dose:** ☐ 5mg/kg IV at weeks 0, 2 and 6 **Maintenance Dose:** ☐ 5mg/kg IV every 8 weeks	☐ ___ Vial(s)	Refills: _______
Simponi®	☐ 100mg/mL SmartJect® AutoInjector ☐ 100mg/mL Prefilled Syringes (PFS)	**Induction Dose:** ☐ 200mg Sub-Q at week 0, then 100mg at week 2 **Maintenance Dose:** ☐ 100mg Sub-Q every 4 weeks	☐ 3 Cartons = 3 x 100mg/mL ☐ 1 Carton = 1 x 100mg/mL	Refills: _______

PRESCRIBER INFORMATION

Anticipated Start Date: ____________________ Prescriber Specialty: ______________________________
Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:______________________________
Prescriber: ______________________________ NPI #: ____________________ Phone #: ____________________
Fax #: ____________________Contact Name: ______________________________
Office Address: ______________________________ City: ______________ State: _____ Zip: _______

I authorize PraxisRx and its representatives to act as an agent to initiate/execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature: ______________________________ Date: ____________________

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