Family PHARMACY • Specialty Care •

INFLAMMATORY BOWEL DISEASE SPECIALTY CARE PROGRAM

Phone: **800-545-3653** • Fax: **844-787-1835**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____

❑ Crohn's Disease ❑ Ulcerative Colitis ❑ Irritable Bowel Syndrome

ICD-10: _____

Other: _____

Serious or active infection present? ❑ Yes ❑ No

Hep B ruled out or treatment started? ❑ Yes ❑ No

TB Test: ❑ Positive ❑ Negative Date: _____

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review
❑ Send Preferred Formulary Alternatives

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ 5-ASA	_____
❑ Biologics	_____
❑ Corticosteroids	_____
❑ Immunosuppressants	_____
❑ Methotrexate	_____
❑ Surgery	_____
❑ Other	_____

4 PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Medication	Dosage & Strength	Direction	QTY	Refills
❑ CIMZIA®	❑ Prefilled Syringe Starter Kit	❑ **Induction Dose:** Inject 400mg SC on day 1, 14 and 28	6	0
	❑ 200mg/ml Prefilled Syringe ❑ 200mg Lyophilized Powder	❑ **Maintenance:** Inject 400mg SC every 4 weeks ❑ _____	2	
❑ HUMIRA®	❑ Crohn's Disease/ Ulcerative Colitis Starter Kit	❑ **Induction Dose:** Inject 160mg SC on day 1, then 80mg SC on day 15, then switch to maintenance dose	6	0
	❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ **Maintenance:** Inject 40mg SC every other week ❑ _____	2	
	❑ *Patient has signed HUMIRA Complete form*			
❑ SIMPONI®	❑ 100mg/ml Smartject® Autoinjector	❑ **Induction Dose:** Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose	3	0
	❑ 100mg/ml Prefilled Syringe	❑ **Maintenance:** Inject 100mg SC every 4 weeks	1	
❑ STELARA®	❑ 130mg/26ml Vial	❑ **Induction Dose:** Patient Weight <55kg: 260mg; >55kg to 85kg: 390mg; >85 kg: 520mg administered IV		0
	❑ 45mg/0.5ml Prefilled Syringe ❑ 90mg/ml Prefilled Syringe ❑ 45mg/0.5ml Vial	❑ **Maintenance Dose:** Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	1	
❑ UCERIS®	❑ 9mg Tablets	❑ Take one tablet daily in the morning with or without food	30	1
❑ XIFAXAN®	❑ 550mg Tablets	❑ Take one tablet three times daily for 14 days	42	
❑ _____	_____	_____		

5 INJECTION TRAINING: ❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PICK UP OR DELIVERY: ❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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