

**Patient Information**

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ SS# \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Please attach copy of front and back of patient's prescription ins. card(s) if applicable  
 Insurance Company Name: \_\_\_\_\_  
 Insurance Company Phone: \_\_\_\_\_  
 Policy holder: \_\_\_\_\_  
 Policy holder Employer: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 RxBIN: \_\_\_\_\_ RxPCN: \_\_\_\_\_

**Prescriber Information**

Practice/Organization Name: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_  
 DEA# \_\_\_\_\_ NPI# \_\_\_\_\_  
 License#: \_\_\_\_\_ Medicaid UPIN#: \_\_\_\_\_  
 Physician Specialty: \_\_\_\_\_  
**Date Shipment Needed:** \_\_\_\_\_  
**Ship to:** ☐ Patient ☐ Prescriber ☐ Infusion Clinic  
 Shipment Address: \_\_\_\_\_ Attn: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
*If shipped to the physician's office, physician accepts on behalf of patient for administration in office.*

**Clinical Information and Prescription**

Diagnosis: ☐ 555.9 Regional enteritis NOS  
 Other: \_\_\_\_\_ ICD 9 Code: \_\_\_\_\_  
 Crohn's Disease Activity Index Score: \_\_\_\_\_  
 Date of Diagnosis or Years with Disease: \_\_\_\_\_  
 Patients Allergies: \_\_\_\_\_  
 Latex allergy: ☐ yes ☐ no  
 Patient Weight: \_\_\_\_\_ Patient Height: \_\_\_\_\_  
 Has the patient had a NEGATIVE tuberculin skin test?: ☐ Yes ☐ No  
 Has Hepatitis B been ruled out? ☐ Yes ☐ No  
 Prior Medications and length of treatment: \_\_\_\_\_  
 Expected First Dose Date: \_\_\_\_\_ Injection Instruction needed: ☐ Yes ☐ No

☐ **Humira®** (adalimumab)  
 Initial Dose: ☐ 160 mg SC on day 1, 80 mg on day 15, then 40mg every other (Crohn's Starter Kit)  
 Maintenance Dose: ☐ 40mg SC every other week  
☐ Humira 40mg/0.8ml PFS ☐ Humira 40mg/0.8ml Pens

☐ **Cimzia®** (certolizumab)  
 Initial Dose: ☐ 400mg SC @ 0, 2, 4 weeks prefilled syringe (Starter Kit)  
☐ 400mg SC @ 0, 2, 4 weeks lyophilized powder (administered in office)  
 Maintenance Dose: ☐ 400mg SC every 4 weeks ☐ 400mg SC every 2 weeks  
☐ Cimzia 2x200mg PFS ☐ Cimzia 2x200mg Powder for Inj Vial Kit

☐ **Remicade®** (infliximab) infuse Remicade in NS 250ml over 2 hours as directed  
 Dose: ☐ 5mg/kg @ 0, 2, 6 weeks ☐ 5mg/kg every 8 weeks ☐ 10mg/kg every 8 weeks  
☐ Other Remicade dosing: \_\_\_\_\_

**Tysabri® (Natalizumab) is available only through the TOUCH™ program. Please Call 1-800-456-2255**

**Quantity Prescribed:** ☐ QS 30 days ☐ QS 90 days ☐ Other: \_\_\_\_\_  
**Refills Authorized:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: \_\_\_\_\_

**X**

**Physician Signature (no stamps)**

**Date**

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