Medley Pharmacy
Sinks Pharmacy
Towne Pharmacy
Steelville Drug
SpecialtyCAREServices

INFLAMMATORY BOWEL DISEASE SPECIALTY CARE PROGRAM

Phone: 844-422-6400 • Fax: 888-850-4018

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 Formulary Preferred 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 ❑ Patient has signed HUMIRA Complete form	❑ Maintenance: Inject 40mg SC every other week ❑ _____	2	
❑ 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	
❑ 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 toPatient's Home ❍ Delivery toPhysician'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 pay