

Ship to: Patient Physician Other All supplies, including syringes and needles, will be dispensed if needed.

Patient Info	Patient Name: _____ DOB: _____ SSN: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Phone: _____ Alt Phone: _____ Alternate Contact Info: _____
	Allergies: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female BSA: _____	Diagnosis: <input type="checkbox"/> B18.1 Hepatitis B <input type="checkbox"/> K58.0 Irritable Bowel Syndrome w/Diarrhea <input type="checkbox"/> K50.90 Crohn's Disease <input type="checkbox"/> K72.9 Hepatic Encephalopathy <input type="checkbox"/> A09 Traveler's Diarrhea <input type="checkbox"/> K51.90 Ulcerative Colitis	<input type="checkbox"/> Other Diagnosis: ICD-10 Code _____
	Height: _____ Weight: _____	Description: _____	
	TB test given: <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____ Date: _____	Date of Diagnosis: _____	

	Medication	Dose/Strength	Directions	Qty	Refills	
Prescription	HEV	<input type="checkbox"/> Vemlidy	<input type="checkbox"/> 25mg	<input type="checkbox"/> Take 1 tablet by mouth once daily with food	30 tab	_____
	HEPATIC	<input type="checkbox"/> Xifaxan	<input type="checkbox"/> 220mg <input type="checkbox"/> 550mg	<input type="checkbox"/> Traveler's Diarrhea: 200mg PO TID x3days <input type="checkbox"/> Hepatic Encephalopathy: 550mg PO BID <input type="checkbox"/> IBS w/Diarrhea: 550mg PO TID x14days <input type="checkbox"/> Other _____	9 tab 60 tab 42 tab	None _____ None
	CROHNS DISEASE / ULCERATIVE COLITIS	<input type="checkbox"/> Cimzia	<input type="checkbox"/> Starter Kit 200mg <input type="checkbox"/> 200mg/ml Prefilled syringe	<input type="checkbox"/> Initial Dose: Inject 400mg SQ once, then repeat at week 2 and 4 <input type="checkbox"/> Maintenance: Inject 400mg SQ every 4 weeks	6 SYR 2 SYR	None
		<input type="checkbox"/> Humira	<input type="checkbox"/> Citrate Free Crohn's/UC Starter Pack (80mg/0.8ml x3pens) <input type="checkbox"/> Citrate Free 40mg/0.4ml Pen <input type="checkbox"/> Citrate Free 40mg/0.4ml PFS	<input type="checkbox"/> Initial Dose: Inject 160mg SQ on day 1, then 80mg on day 15 <input type="checkbox"/> Maintenance: Inject 40mg SQ every other week starting day 29 <input type="checkbox"/> Other _____	3 2	None
		<input type="checkbox"/> Simponi	<input type="checkbox"/> 100mg/ml autoinjector <input type="checkbox"/> 100mg/ml prefilled syringe	<input type="checkbox"/> Initial Dose: Inject 200mg SQ at week 0, then 100mg at week 2 <input type="checkbox"/> Maintenance: Inject 100mg SQ every 4 weeks starting on week 6	3 1	None
		<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg/25mg SDV <input type="checkbox"/> 90mg/ml Prefilled Syringe	Initial Dose: <input type="checkbox"/> ≤ 55kg: 260mg (2 vials) IV as single dose <input type="checkbox"/> 55kg to 85kg: 390mg (3 vials) IV as single dose <input type="checkbox"/> > 85kg: 520mg (4 vials) IV as single dose <input type="checkbox"/> Maintenance: Inject 90mg SQ every 8 weeks; begin maintenance dose 8 weeks after the IV induction dose	2 vials 3 vials 4 vials 1 SYR	None None None
		<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet	<input type="checkbox"/> Initial Dose: 10mg PO BID x8weeks or _____ weeks Maintenance Dose: <input type="checkbox"/> 5mg PO BID <input type="checkbox"/> 10mg PO BID	60 tab	_____
		<input type="checkbox"/> Zeposia	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 0.92mg capsules	<input type="checkbox"/> Initial Dose: Titration Regimen Day 1-4: 0.23mg PO QD; Day 5-7: 0.46mg PO QD; Day 8 and thereafter: 0.92mg PO QD <input type="checkbox"/> Maintenance: 0.92mg po QD	1 Kit (37 caps) 30 caps	0
	OTHER	<input type="checkbox"/> Lactulose Packet	<input type="checkbox"/> 10gm/packet (lactulose powder, for solution): Dissolve contents of each packet in half a glass (4oz) of water before administration (Check if applicable) <input type="checkbox"/> I authorize to change to Lactulose 10gm/15ml solution if packet is not covered	<input type="checkbox"/> Chronic Constipation Initial dose (check dose and duration): <input type="checkbox"/> 10gm <input type="checkbox"/> 20gm PO QD for _____ days Additional therapy (check if applicable): <input type="checkbox"/> 10gm <input type="checkbox"/> 20gm <input type="checkbox"/> 30gm <input type="checkbox"/> 40gm PO QD <input type="checkbox"/> Hepatic Encephalopathy (Treatment and Prophylaxis) Initial dose (check dose): <input type="checkbox"/> 20gm <input type="checkbox"/> 30gm PO every _____ hour until laxative achieved Maintenance dose (check dose and frequency): <input type="checkbox"/> 20gm <input type="checkbox"/> 30gm PO <input type="checkbox"/> TID <input type="checkbox"/> QID	QS	None
		<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other: _____	_____	_____
		<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other: _____	_____	_____

PRIOR AUTHORIZATION

Prescriber Information	Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
	Address: _____
	City: _____ Zip: _____ Tel: _____ Fax: _____
	Contact Person: _____

PRESCRIBER SIGNATURE

(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e script.

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ **Dispense as written (DAW) Date:** ____/____/____

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