

Ship to: Patient Physician Other

All supplies, including syringes and needles, will be dispensed if needed.

Patient Information	Patient Last 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 Information	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Diagnosis: <input type="checkbox"/> B18.1 Hepatitis B <input type="checkbox"/> K58.0 IBS 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: _____ Description: _____ Date of Diagnosis: _____	Has TB test been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Height: _____		Does patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Weight: _____		Start Date: _____
	BSA: _____		Review Date: _____

	Medication	Dose/Strength	Directions	Qty	Refills	
Prescription Information	HBV <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: Take 200mg PO TID x3days <input type="checkbox"/> Hepatic Encephalopathy: Take 550mg PO BID <input type="checkbox"/> IBS w/Diarrhea: Take 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 _____ 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 _____ None
		<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg ER tablet <input type="checkbox"/> 30mg ER tablet <input type="checkbox"/> 45mg ER tablet	<input type="checkbox"/> Initial Dose: Take 45mg PO QD x8weeks <input type="checkbox"/> Maintenance: Take 15mg PO QD <input type="checkbox"/> Other _____ <i>(Maintenance dose of 30mg QD may be considered for patients with refractory, severe, or extensive disease)</i>	30 30	1 _____ _____ _____ _____
		<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 _____ 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: Take 0.23mg PO QD Day 5-7: Take 0.46mg PO QD Day 8 and thereafter: Take 0.92mg PO QD <input type="checkbox"/> Maintenance: Take 0.92mg po QD	1 Kit (37 caps) 30 caps	0 _____ _____	

		Medication	Dose/Strength	Directions	Qty	Refills
Prescription Information	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	QS	None
				<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	_____	_____
				<input type="checkbox"/> Other: _____	_____	_____
	<input type="checkbox"/> Other	_____	_____	_____	_____	_____

PRIOR AUTHORIZATION

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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