

Deliver to: Patient's Home Prescriber's Office Other: _____ Hold shipment until notified by prescriber Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work/Mobile Phone: _____
 First Name: _____ Home Address: _____
 S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____
 Guardian/Caregiver: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____
 Subscriber Name: _____ Policy #: _____ BIN/PCN: _____
 Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ MD DO NP PA License #: _____ NPI #: _____ DEA #: _____
 Practice Name: _____ Phone: _____ Fax: _____
 Address: _____ Office Contact: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: _____ Secondary ICD-10: _____ Tested Negative for TB? Yes No
 Allergies: _____ Sulfasalazine Oral Corticosteroids Asathioprine
 Meds Tried & Failed: _____ 6-mercaptopurine Topical (rectal) corticosteroids 5-ASA
 Congestive Heart Failure? Yes No Active Infection? Yes No Biologics: _____

5. Prescription Information

Medication	Dose/Strength	Directions	Dispense	Refills
CIMZIA®	<input type="checkbox"/> 200 mg Starter Kit <input type="checkbox"/> 200 mg PFS Kit	<input type="checkbox"/> Initial dose: Inject 400 mg SC once weekly at weeks 0, 2, & 4		
	<input type="checkbox"/> 200 mg Vial Kit	<input type="checkbox"/> Maintenance dose: Inject 400 mg SC Q4wks		
ENTYVIO®	<input type="checkbox"/> 300 mg/20 mL LYO	• Infuse 300 mg IV over 30 minutes at weeks 0, 2, and 6, then Q8 weeks thereafter		
HUMIRA®	Crohn's/UC Starter Pack: <input type="checkbox"/> 6x40 mg/0.8 mL Pens	<input type="checkbox"/> Inject 160 mg SC on day 1, then inject 80 mg on day 15, then inject 40 mg Q2wks <input type="checkbox"/> Inject 80 mg SC on day 1, 2, and 15, then inject 40 mg Q2wks		
	Pediatric Crohn's Disease Starter Pack: <input type="checkbox"/> 6x40 mg/0.8 mL PFS <input type="checkbox"/> 3x40 mg/0.8 mL PFS <input type="checkbox"/> 3x80 mg/0.8 mL PFS <input type="checkbox"/> 1x80 mg/0.8 mL and 1x40 mg/0.8 mL PFS	<input type="checkbox"/> 17kg (37 lbs) to <40kg (88 lbs): Inject 80 mg SC on day 1, then inject 40 mg SC on day 15, then on day 29 transition to maintenance dosing <input type="checkbox"/> >40kg (88lbs): Inject 160 mg SC, then inject 80 mg SC on day 15, then on day 29 transition to maintenance dosing		
	Maintenance Dosing: <input type="checkbox"/> 20mg/0.2mL PFS <input type="checkbox"/> 20mg/0.4mL PFS <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 40mg/0.8mL PFS <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 40mg/0.8mL Pen	<input type="checkbox"/> Inject 20mg SC QOW <input type="checkbox"/> Inject 40mg SC QOW		
SIMPONI®	<input type="checkbox"/> 100 mg/mL PFS	<input type="checkbox"/> Initial dose: Inject 200 mg SC at week 0, then 100 mg SC at week 2, then 100 mg SC Q4wks		
	<input type="checkbox"/> 100 mg/mL SmartJect® Autoinjector	<input type="checkbox"/> Maintenance dose: Inject 100 mg SC Q4wks		
STELARA®	<input type="checkbox"/> 130 mg/25 mL SDV	<input type="checkbox"/> ≤55kg: Infuse 260 mg (2 vials) over at least 1 hour		
	<input type="checkbox"/> 90 mg/mL PFS	<input type="checkbox"/> >55kg to 85kg: Infuse 390 mg (3 vials) over at least 1 hour <input type="checkbox"/> >85kg: Infuse 520 mg (4 vials) over at least 1 hour <input type="checkbox"/> Maintenance Dose: Inject 90 mg SC 8 weeks after initial IV dose, then Q8wks thereafter		
XELJANZ®	<input type="checkbox"/> 5 mg tabs	<input type="checkbox"/> Initial dose: Take 10 mg PO BID for 8 weeks		
	<input type="checkbox"/> 10 mg tabs	<input type="checkbox"/> Maintenance dose: Take 5 mg PO BID <input type="checkbox"/> Maintenance dose: Take 10 mg PO BID		
XIFAXAN®	<input type="checkbox"/> Traveler's Diarrhea: 200 mg tabs	• Take 200 mg PO TID for three days		
	<input type="checkbox"/> Hepatic Encephalopathy: 550 mg tabs	• Take 550 mg PO BID		
	<input type="checkbox"/> Irritable Bowel Syndrome w/Diarrhea: 550 mg tabs	• Take 550 mg PO TID for 14 days		

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Account Manager

Patient Signature _____ Date ____ / ____ / ____

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

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ **PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ **PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____