JOSEFS PHARMACY

2100 New Bern Ave,
Raleigh, NC 27610
P. 855-326-9112 / F. 855-326-9114

Gastroenterology

Date: _____ Needs by date: _____ Ship to: ☐Patient ☐Office 1st dose ☐Office All doses

Prescriber information

Prescriber:	NPI:
Supervising physician:	NPI:
Address:	
Phone:	Fax:
Office contact:	

Patient information

Name:	Sex: ☐M ☐F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight: Height:	Allergies:		
Primary language: ☐English ☐Spanish ☐Other:	Needs interpreter: ☐Yes ☐No		

Please include copies of the patient's insurance card or local pharmacy information.

Medical information

Diagnosis/ICD-10: ☐ K50.90 Crohn's Disease ☐ K51. Ulcerative Colitis ☐ Other: _____ ICD-10: _____

TB/PPD Test: ☐Yes ☐No Test result: _____ Test date: _____

Prior failed therapies:	Duration	Duration	Duration
☐Azathioprine		☐Mesalamine	☐Sulfasalazine
☐Corticosteroids		☐Methotrexate	☐ _____
☐Mercaptopurine		☐Remicade	☐ _____

Prescription information			Quantity	Refills
☐Cimzia®	200mgx2 Pre-filled syringe	☐Initial: Inject 400mg subcutaneously at weeks 0, 2, and 4 ☐Maintenance: Inject 400mg subcutaneously every 28 days	1 starter kit 4 week supply	_____
☐Dificid	200mg tablet	Take one tablet by mouth twice daily		_____
Humira ☐40mg/0.8ml ☐40mg/0.4ml citrate free	☐Crohn's/UC Starter Kit ☐Pen ☐Pre-filled syringe	☐Initial: Inject 160mg subcutaneously day 1, then 80mg day 15 ☐Maintenance: Inject 40mg subcutaneously every 14 days ☐Other: _____	1 starter kit 4 week supply	_____
☐Remicade	Vials	☐Initial: Infuse _____ mg day 0, day 14, and day 42 ☐Maintenance: Infuse _____ mg every 8 weeks	_____ _____	_____
☐Simponi	☐100mg SmartJect ☐100mg Pre-filled syringe	☐Initial: Inject 200mg subcutaneously week 0, then 100mg week 2 ☐Maintenance: Inject 100mg subcutaneously every 28 days	Loading dose 4 week supply	_____
☐Stelara	☐130mg vials ☐90mg Pre-filled syringe	Initial: Infuse☐260mg ☐390mg ☐520mg intravenously week 0 Maintenance: Inject 90mg subcutaneously every 8 weeks — Begin 8 weeks after initial infusion	_____ _____	_____
☐Xeljanz	☐10mg tablets ☐5mg tablets	☐Initial: Take 10mg by mouth twice daily ☐Maintenance: Take 5 mg by mouth twice daily ☐Maintenance: Take 10mg by mouth twice daily		
☐Xifaxan	550mg tablets	Take one tablet by mouth three times daily		_____
☐Other	_____	_____	1 month supply	_____

PHYSICIAN SIGNATURE REQUIRED

By signing below I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies.

Stamp signature not allowed, physician attests this is his/her legal signature.

_____ **Dispense as Written / Brand Medically Necessary**

_____ **Substitution allowed**