Gastroenterology

Phone: 417-719-4510
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specialty.alpspharmacy.com

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, ZIP: _____
Home Phone: _____ Alternate Phone: _____
Caregiver: _____ Email: _____
DOB: _____ Social Security#: _____
Gender: ☐ Male ☐ Female Comorbidities: _____
Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Address: _____
City, State, ZIP: _____
Phone: _____ Fax: _____
NPI: _____ Tax ID: _____
DEA: _____
Office Contact: _____ Phone: _____
Contact Email: _____

INSURANCE INFORMATION

Please fax a copy of patients' insurance cards (prescription and medical, FRONT and BACK) including any secondary insurance.

CLINICAL INFORMATION [Please fax all pertinent clinical and lab information and/or attach separate sheet if needed.]

Diagnosis: ☐ K50.0 (Crohn's Disease of the Small Intestine) ☐ K50.1 (Crohn's Disease of the Large Intestine) ☐ K50.8 (Crohn's Disease of Both Intestines)
☐ K50.9 (Crohn's Disease, unspecified) ☐ K51.0 (Ulcerative Pancolitis) ☐ K51.2 (Ulcerative Procolitis) ☐ K51.3 (Ulcerative Rectosigmoiditis)
☐ K51.5 (Left Sided Colitis) ☐ K51.8 (Other Ulcerative Colitis) ☐ K51.9 (Ulcerative Colitis, unspecified) ☐ Other: _____

Prior Therapy ☐ Yes ☐ No	Approx. Therapy Start/End Dates	Reason for Discontinuation of Therapy	Prior History
☐ Cimzia®	_____ to _____		☐ 5-ASA
☐ Humira®	_____ to _____		☐ Immunosuppressants (6-MP/other)
☐ Remicade®	_____ to _____		☐ Corticosteroids
☐ Simponi®	_____ to _____		☐ Methotrexate
☐ Stelara®	_____ to _____		☐ Surgery
☐ Other: _____	_____ to _____		☐ Other: _____

Date of Diagnosis: _____
TB test?: ☐ Yes ☐ No Negative TestDate: _____
BSA %: _____
Concomitant Medications: _____
_____
Additional Information: _____

PRESCRIPTION INFORMATION

Medication	Directions	Quantity		Refills
☐ Cimzia®	☐ 400 mg Sub-Q at weeks 0, 2 and 4	☐ 6 x 200 mg/mL	☐ PFS	
	☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 2 x 200 mg/mL	☐ PFS	
☐ Humira® (adalimumab)	☐ Inject 160 mg (4 pens) Sub-Q on day 1, then 80 mg (2 pens) on day 15, then 40 mg (1 pen) on day 29 and every other week thereafter	☐ 1 Chrons Starter Kit = 6 x 40 mg/0.8 mL device	☐ Starter Kit	
	☐ Inject 40 mg Sub-Q every other week ☐ Other: _____	☐ 1 Carton = 2 x 40 mg/0.8mL ☐ Other: _____	☐ Pen ☐ PFS	
☐ Humira® Citrate-Free (adalimumab)	☐ Inject 160 mg (1 80 mg pen) Sub-Q on day 1, then 80 mg (1 80 mg pen) on day 29, then 40 mg (1 pen) on day 29 and every other week thereafter	☐ 1 Chrons Starter Kit = (2 x 80 mg/0.8 mL device)	☐ Starter Kit	
	☐ Inject 40 mg Sub-Q every other week ☐ Other: _____	☐ 1 Carton = 2 x 40 mg/0.4mL ☐ Other: _____	☐ Pen ☐ PFS	
☐ Simponi®	☐ 200 mg Sub-Q at week 0, 100 mg at week 2 ☐ 100 mg Sub-Q every 4 weeks	☐ 3 x100 mg/mL ☐ 1 x100 mg/mL	☐ PFS ☐ Autoinjector	
☐ Stelara® (ustekinumab)	☐ Inject 90 mg sub-Q 8 weeks following initial intravenous dose, then every ☐ 8 weeks thereafter	☐ 1 x 90 mg/mL PFS	☐ PFS	

☐ Other Medication: _____ Dose: _____ Quantity: _____ Refills: _____
Direction(s): _____

INJECTION TRAINING

☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

PRESCRIPTION DELIVERY

☐ Patient's Home ☐ Physician's Office ☐ Patient Will Pick Up in Pharmacy Date Issued: _____ Needs by Date: _____

PRESCRIBER AUTHORIZATION

I authorize Alps Pharmacy, including it's representatives and subcontractors, to act as my agent to initiate and execute the insurance prior authorization, patient assistance, and nursing programs. If Alps Pharmacy is unable to fulfill this prescription, I authorize Alps Pharmacy to forward this information and data related to the coverage of this prescription to another pharmacy.

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____
PRODUCT SUBSTITUTION PERMITTED ***Dispense As Written***

CONFIDENTIALITY NOTICE