RESTORE Rx SPECIALTY PHARMACY — Crohn's / Ulcerative Colitis Enrollment Form S-Z

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ Group#: _____

Diagnosis

- ☐ K50.00 Crohn's Disease of small instestine without complications
- ☐ K50.10 Crohn's Disease of large instestine without complications
- ☐ K50.80 Crohn's Disease of both small and large instestine without complications
- ☐ K50.90 Crohn's Disease, unspecified, without complications
- ☐ Other: _____
  ICD 10: _____

- ☐ K51.20 Ulcerative (chronic) proctitis without complications
- ☐ K51.30 Ulcerative (chronic) rectosigmoiditis without complications
- ☐ K51.50 Left sided colitis without complications
- ☐ K51.80 Other ulcerative colitis without complications
- ☐ K51.90 Ulcerative colitis, unspecified, without complications
- ☐ Other: _____
  ICD 10: _____

Clinical Information

To expedite prior authorization, please attach PPD results, lab results, clinical office notes, and past treatment history.

Has patient previously been treated for this condition? ☐ Yes ☐ No Does patient have a latex allergy? ☐ Yes ☐ No
If yes, medication/therapy failed (length of therapy): _____
Has patient received PPD (tuberculosis) skin test? ☐ Yes ☐ No Date: _____/_____/_____ Results: ☐ Positive ☐ Negative
Has patient been tested for Hepatitis B? ☐ Yes ☐ No If positive, has treatment been initiated? ☐ Yes ☐ No

Prescription

Medication	Strength	Directions	Quantity	Refills
☐ Simponi® *only indicated for UC*	☐ 100mg/ml PFS ☐ 100mg/ml Smartject® Autoinjector	☐ Induction: Inject 200mg (2 injections) SQ at week 0, then inject 100mg (1 injection) SQ at week 2	#3	0 refills
		☐ Maintenance: Inject 100mg SQ every 4 weeks	#1	
☐ Stelara®	130mg/26ml vial	☐ Induction: (Dosed by weight) Infuse _____mg intravenously as single dose, begin maintenance in 8 weeks *Up to 55kg → 260mg = 2 vials* *Greater than 55kg to 85kg → 390mg = 3 vials* *Greater than 85kg → 520mg = 4 vials* Patient weight _____kg	Quantity Sufficient x1 dose	0 refills
	☐ 45mg/0.5ml vial ☐ 90mg/ml PFS	☐ Maintenance: Inject 90mg SQ 8 weeks after initial IV dose, then every 8 weeks thereafter	Quantity Sufficient x1 dose	
☐ Xeljanz® *only indicated for UC*	10mg tablet	☐ Induction: Take 1 tablet orally twice daily for 8 weeks	#60	1 refill
	5mg tablet	☐ Maintenance: Take 1 tablet orally twice daily	#60	
☐ Xeljanz XR® *only indicated for UC*	22mg tablet	☐ Induction: Take 1 tablet orally once daily for 8 weeks	#30	1 refill
	11mg tablet	☐ Maintenance: Take 1 tablet orally once daily	#30	

Supportive

Medication	Strength	Directions	Quantity	Refills
☐ Dificid®	200mg tablet	Take 1 tablet orally twice daily food for 10 days	#20	
☐ Xifaxan®	☐ 200mg tablet ☐ 550mg tablet	Take _____ tablet(s) orally _____ times per day		

Is patient new to this therapy: ☐YES ☐NO | **Ship to:** ☐Patient ☐Office ☐Other | **Need by Date:** _____

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
Email: _____

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right. ☐