APEX SPECIALTY PHARMACY

GASTROENTEROLOGY

Benefit Investigation + Prior Authorization Support

Date _____
Ship to:: ☐ Patient ☐ Provider
☐ Injection Training Requested

PATIENT INFORMATION::

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office Fax:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS (ICD-10 // ICD-9)

☐ K50. ____ // 555.0 Crohn's Disease ☐ K51. ____ // 556.9 Ulcerative Colitis ☐ Other:

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION::

Immunosuppressants	☐ 5-ASA ☐ Azathioprine ☐ Budesonide ☐ Mercaptopurine ☐ Mesalamine ☐ Prednisone ☐ Sulfasalazine	
Biologics	☐ Cimzia ☐ Entyvio ☐ Humira ☐ Remicade ☐ Simponi ☐ Stelara ☐ Xeljanz ☐ Xifaxan	
PPD/Chest X-Ray for TB?	☐ Yes ☐ No	Drug Allergies (list):

PRESCRIPTION INFORMATION::

☐ Cimzia	☐ Prefilled Syringe ☐ LYO Powder	☐ Initial: Inject 400mg SQ at weeks 0, 2 and 4 (qty 3 kits) ☐ Maint: Inject _____mg SC every: ☐ 2 ☐ 4 wks (qty _____)	Refill: 0 Refill:
☐ Dificid	☐ 200mg Tablet	1 Tablet Twice Daily (qty 20)	Refill: 0
☐ Humira Induction ***citrate free***	☐ 40mg/0.8ml PEN (qty 6) ☐ 80mg/0.8ml PEN* (qty 3)	☐ Inject 160mg SQ on Day 1, then 80mg on day 15 ☐ Inject 80mg SQ on Day 1, 2 and 15	Refill: 0
☐ Humira Maintenance ***citrate free***	☐ 40mg/0.8ml PEN ☐ 40mg/0.8ml PFS ☐ 40mg/0.4ml PEN* ☐ 40mg/0.4ml PFS*	☐ Inject 40mg SQ every-other-week (qty 2)	Refill:
☐ Simponi Induction	☐ 100mg PFS ☐ 100mg SmartJect	☐ Inject 200mg SQ at week 0, then 100mg at week 2 (qty 3)	Refill: 0
☐ Simponi Maintenance	☐ 100mg PFS ☐ 100mg SmartJect	☐ Inject 100mg every 4 weeks (qty 1)	Refill:
☐ Stelara	☐ 130mg Vial (Start) ☐ 90mg PFS (Maint.)	☐ Start: _____ mg IV at day 0 (qty _____) ***WEIGHT** _____ ☐ Maint: Inject 90mg SC at week 8, then every 8 weeks	Refill: 0 Refill:
☐ Xeljanz	☐ 5mg Tablet ☐ 10mg Tablet	☐ Start: 10mg twice daily: ☐ 8 weeks ☐ ____ weeks (qty 60) ☐ Maint: ☐ 5mg twice daily ☐ 10mg twice daily (qty 60)	Refill: 0 Refill:
☐			

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN