

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____ Ethnicity: _____
Language: _____ Wt: _____ kg ☐ lbs Ht: _____ cm ☐ in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Bin: _____ PCN: _____
ID: _____ Group #: _____

Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription

Form/Strength/Directions For Use

Quantity Refills

<input type="checkbox"/> Xifaxan	<input type="checkbox"/> 200 mg _____ mg po <input type="checkbox"/> BID <input type="checkbox"/> TID for _____ days <input type="checkbox"/> 550 mg _____ mg po <input type="checkbox"/> BID <input type="checkbox"/> TID for _____ days		
<input type="checkbox"/> Simponi	<input type="checkbox"/> Initial Dosing: 200 mg SC week 0 then 100mg SC week 2 <input type="checkbox"/> Other: <input type="checkbox"/> Ongoing treatment: 100mg SC every 4 weeks <input type="checkbox"/> Other:		
<input type="checkbox"/> Cimzia (200mg Vials for PFS)	<input type="checkbox"/> Lyophilized vial <input type="checkbox"/> Pre-Filled Syringe <input type="checkbox"/> Initial Dosing: 400mg SC at 0, 2, 4 weeks (ongoing treatment below) <input type="checkbox"/> Ongoing treatment (after initial dosing): 400mg every 4 weeks		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg PFS SC x1 followed by 45mg PFS SC in 4 weeks (For patients weighing < 100kg) <input type="checkbox"/> 90mg PFS SC x1 followed by 90mg PFS SC in 4 weeks (For patients weighing > 100kg) Maintenance Dosing: <input type="checkbox"/> 45mg PFS SC every 12 weeks <input type="checkbox"/> 90mg PFS SC every 12 weeks <input type="checkbox"/> 260mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg followed by <input type="checkbox"/> 90mg IV every 8 weeks		
<input type="checkbox"/> Humira (Supplied as 40mg pens or as PFS)	<input type="checkbox"/> Initial Dosing: Chron's/Ulcerative Colitis Starter Pack - six 40mg single dose pens 160mg (four 40mg injections) SC x one dose (day 1) then 80mg SC x one two weeks later (day 15) <input type="checkbox"/> Ongoing treatment: <input type="checkbox"/> Pen or <input type="checkbox"/> PFS 40mg SC every other week (Start 29 days after initial dosing) <input type="checkbox"/> Other:		
<input type="checkbox"/> Humira Pediatric (Supplied as PFS)	Initial dosing for children >= 6 and >= 40kg: <input type="checkbox"/> 4x40 mg inj SC on Day 1 then 2x40mg inj SC 2 weeks later on Day 15 (tray of 6) <input type="checkbox"/> 2x40 mg inj SC on Days 1 and 2 then 2x40mg inj SC 2 weeks later on Day 15 (tray of 6) Initial dosing for children >= 6 and weighing 17kg to < 40kg: <input type="checkbox"/> 2x40 mg inj SC on Day 1 then 1x40mg inj SC 2 weeks later on Day 15 (tray of 3) Maintenance: <input type="checkbox"/> 40mg SC every other week <input type="checkbox"/> 20mg SC every other week		
<input type="checkbox"/> Relistor	<input type="checkbox"/> 150mg tab <input type="checkbox"/> 8mg/0.4ml Sol'n for Inj <input type="checkbox"/> 12mg/0.6ml Sol'n for Inj Sig: _____		
<input type="checkbox"/> Other			

Information Needed to Obtain Prior Authorization

Primary Diagnosis: ☐ ICD-10 ☐ Other: _____
Weight: _____ pounds Allergies: _____
Failed Therapies: _____ Please provide current list of medications: _____

****For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availability (or insurance preference) will be dispensed.**

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize Wellgistics Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization and appeal process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Wellgistics Pharmacy.

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