Cosentino's SPECIALTY CARE

INFLAMMATORY BOWEL DISEASE SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____
❑ Crohn's Disease ❑ Ulcerative Colitis ❑ Irritable Bowel Syndrome
ICD-10: _____
Other: _____
Serious or active infection present? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
TB Test: ❑ Positive ❑ Negative Date: _____
Pregnancy test : ❑ Positive ❑ Negative Date: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ 5-ASA	
❑ Biologics	
❑ Corticosteroids	
❑ Immunosuppressants	
❑ Methotrexate	
❑ Surgery	
❑ Other	

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ AMJEVITA™	❑ 10mg/0.2ml Prefilled Syringe ❑ 20mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Prefilled Syringe ❑ 40mg/0.8ml Pen	**Ulcerative Colitis and Crohn's Disease: For Adult Dose:** ❑ **Induction Dose:** Inject 160mg on Day 1 (given in one day or split over two consecutive days), 80mg on Day 15 ❑ **Maintenance Dose:** Inject 40mg every other week starting on Day 29 **Ulcerative Colitis:** Discontinue in patients without evidence of clinical remission by eight weeks (Day 57)		
❑ CIMZIA®	❑ 200mg Lyophilized Powder ❑ 200mg mg/ml single-dose Prefilled Syringe	❑ **Induction Dose:** Inject 400mg SC on day 1, 14 and 28 ❑ **Maintenance:** Inject 400mg SC every 4 weeks ❑ _____	6 2	0
❑ HUMIRA®	❑ **Crohn's Disease/Ulcerative Colitis** 80mg/0.8ml Starter Package ❑ **Crohn's Disease/Ulcerative Colitis** 40mg/0.4ml Starter Package ❑ 40mg/0.4ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 80mg/0.8ml Prefilled Syringe *All strengths and dosages listed are Humira® Citrate Free*	❑ **Crohn's disease/ulcerative colitis for adult patients:** ❑ **Induction Dose:** Inject 160mg on day 1 and 80mg on day 15 ❑ **Maintenance Dose:** Inject 40mg every other week starting on day 29 ❑ **Maintenance:** Inject 40mg SC every other week ❑ _____ ❑ *Patient has signed HUMIRA Complete form*	3 2	
❑ SIMPONI®	❑ 100mg/ml Smartject® Autoinjector ❑ 100mg/ml Prefilled Syringe	❑ **Induction Dose:** Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose ❑ **Maintenance:** Inject 100mg SC every 4 weeks	3 1	0
❑ STELARA®	❑ 130mg/26ml Vial ❑ 90mg/ml Prefilled Syringe	❑ **Induction Dose:** Patient Weight <55kg: 260mg; >55kg to 85kg: 390mg; >85kg: 520mg administered IV ❑ **Maintenance Dose:** Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	 1	0
❑ SKYRIZI®	❑ 180mg/1.2ml (150mg/ml) in each single-dose prefilled cartridge ❑ 360mg/2.4ml (150mg/ml) single-dose prefilled cartridge ❑ 600mg/10ml (60mg/ml) in each single-dose vial	❑ **Induction Dose:** 600mg by intravenous infusion over a period of at least one hour at Week 0, Week 4, and Week 8 ❑ **Maintenance dose:** ❑ 180mg or 360mg by subcutaneous injection at Week 12, and every 8 weeks thereafter		
❑ UCERIS®	❑ 9mg ER Tablets	❑ Take one 9mg tablet once daily in the morning with or without food for up to 8 weeks	30	
❑ _____	_____	_____		

PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

v10.1_052923

Cosentino's SPECIALTY CARE

INFLAMMATORY BOWEL DISEASE SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____
❑ Crohn's Disease ❑ Ulcerative Colitis ❑ Irritable Bowel Syndrome
ICD-10: _____
Other: _____
Serious or active infection present? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
TB Test: ❑ Positive ❑ Negative Date: _____
Pregnancy test : ❑ Positive ❑ Negative Date: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ 5-ASA	
❑ Biologics	
❑ Corticosteroids	
❑ Immunosuppressants	
❑ Methotrexate	
❑ Surgery	
❑ Other	

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ RINVOQ® XR	Crohn's Disease/Ulcerative Colitis ❑ 15mg ER Tablet ❑ 30mg ER Tablet ❑ 45mg ER Tablet	❑ **Crohn's Disease** ❑ **Induction Dose:** Take 45mg orally once daily for 12 weeks ❑ **Ulcerative Colitis** ❑ **Induction Dose:** Take 45mg orally once daily for 8 weeks	28	
		❑ **Maintenance Dose:** Take 15mg orally once daily ❑ Take 15mg orally once daily ❑ Take 30mg orally once daily (Considered for patients with refractory, severe, or extensive disease)		
		"If an adequate response is not achieved, consider increasing the dosage to 30mg orally once daily."	30	
❑ VIBERZI®	❑ 75mg Tablet ❑ 100mg Tablet	❑ 100mg orally twice a day with food ❑ 75mg orally twice a day with food **"Who is unable to tolerate the 100 mg dose, mild or moderate hepatic impairment, moderate or severe renal impairment, and end stage renal disease not yet on dialysis reduce dose to 75mg."**	60	
❑ XELJANZ® ❑ XELJANZ® XR	❑ 5mg Tablet ❑ 10mg Tablet ❑ 11mg Tablet ❑ 22mg Tablet	❑ **Induction Dose:** ❑ Take 10mg orally twice daily for at least 8 weeks ❑ Take 22mg orally once daily for at least 8 weeks ❑ Take 10mg orally twice daily for at least 16 weeks ❑ Take 22mg orally once daily for at least 16 weeks		
		❑ **Maintenance Dose:** ❑ Take 5mg orally twice daily ❑ Take 10mg orally twice daily ❑ Take 11mg orally once daily ❑ Take 22mg orally once daily	60 30	
		"Moderate and severe renal impairment or moderate hepatic impairment reduce dose to 5mg once daily or 11mg once daily."		
❑ XIFAXAN®	❑ 550mg Tablets	❑ Take one tablet three times daily for 14 days **"Patients who experience recurrence can be retreated up to 2 times with the same regimen"**	42	
❑ YUSIMRY™	❑ 40mg/0.8ml Single-Dose Prefilled Syringe ❑ 40mg/0.8ml Single-Dose Prefilled Pen	❑ **Induction Dose:** Inject 160mg SC on day 1 and 80mg on day 15 ❑ **Maintenance Dose:** Inject 40mg SC every other week starting on day 29		
❑ ZEPOSIA®	❑ 0.23mg ❑ 0.46mg ❑ 0.92mg	❑ **Induction Dose:** ❑ Take 0.23mg once daily on days 1-4 ❑ Take 0.46mg once daily on days 5-7	30	
		❑ **Maintenance Dose:** ❑ Take 0.92mg orally once daily on day 8 and thereafter		
❑ _____	_____	_____		

PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

v10.1_052923