Crohn's Disease
Ulcerative Colitis (drugs S-Z)

(Simponi®, Stelara®)

Employee Owned Thrifty White PHARMACY Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
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

Clinical Information (Please fax all pertinent clinical and lab information)

Crohn's Disease: ☐ K50.0 (Crohn's Disease of the **Small** Intenstine) ☐ K50.1 (Crohn's Disease of the **Large** Intenstine)
☐ K50.8 (Crohn's Disease of **Both** Intenstines) ☐ K50.9 (Crohn's Disease, unspecified)
Ulcerative Colitis: ☐ 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: ☐ _____
Diagnosis Date: _____ TB Test: ☐ Yes ☐ No Neg. Test Date: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

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

Prescription

§ Cimzia® and Humira® are available on the Crohn's Disease/Ulcerative Colitis Enrollment Form A-R §

☐ **Simponi® (golimumab)**	☐ Inject 200 mg subcut at week 0, then 100 mg at week 2	☐ 3 x 100 mg/mL	☐ SmartJect® Autoinjector ☐ PFS	0
	☐ Inject 100 mg subcut every 4 weeks	☐ 1 x 100 mg/mL	☐ SmartJect® Autoinjector ☐ PFS	_____
☐ **Stelara® (ustekinumab)**	☐ Infuse 260 mg intravenously over no less than one hour (≤55kg) ☐ Infuse 390 mg intravenously over no less than one hour (>55 kg to <85 kg) ☐ Infuse 520 mg intravenously over no less than one hour (>85 kg)	☐ 2 x 130 mg/26 mL ☐ 3 x 130 mg/26 mL ☐ 4 x 130 mg/26mL	☐ Vials	0
	☐ Inject 90 mg subcut 8 weeks following initial intravenous dose, then every 8 weeks thereafter	☐ 1 x 90 mg/mL	☐ PFS	_____
	Patient eligible for self-administration: ☐ Yes ☐ No			
	Date of last infusion: _____			

Injection Training Provided by: ☐ Physician's Office ☐ Pharmacy ☐ Other: _____

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

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize Thrifty White Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization 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 Thrifty White Specialty Pharmacy.

Reset Form