CoxHealth at Home Gastroenterology

PHONE: 1-855-419-4663
FAX: 1-417-269-0692

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑kg ❑lbs Ht:_____❑cm ❑in
Address: _____
Apt/Suite: _____ City:_____ State:____ Zip:_____
Phone:_____ Alternate Phone:_____
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

Physician Name:_____
NPI #: _____
Address: _____
City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to physician: ❑ 1st Fill ❑ Always ❑ Never

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

ICD-10/Diagnosis Code:
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 the **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: ❑ _____
Date of Diagnosis: _____ Date of negative TB test: _____ Any prior treatment: ❑ No ❑ Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

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

Prescription

Cimzia®	Starter: ❑ Inject 400 mg subq at weeks 0, 2 and 4 Qty: ❑ 1 starter kit (6 x 200mg/mL PFS) ❑ 3 cartons (2 x 200mg/mL Vials/carton)		
	Maintenance: ❑ Inject 400 mg subq every 4 weeks Qty: 1 carton (2 x 200 mg) ❑ PFS ❑ Vials		Refills: _____
Humira® Citrate-free (Adults)	Starter: ❑ Inject 160 mg subq Day 1; then 80 mg on Day 15 ❑ Inject 80 mg subq on Day 1 and Day 2; then 80 mg on Day 15 Qty: 1 starter kit (3 x 80mg/0.8mL PENS)		
	Maintenance: ❑ Starting on Day 29, 40 mg subq every other week Qty: 1 box (2 x 40mg/0.4mL PENS)		Refills: _____
Simponi ®	Starter: ❑ Inject 200 mg subq at week 0; then 100 mg at week 2 Qty: 3 box (1 x 100 mg/1 mL) ❑ SmartJet™ ❑ PFS		
	Maintenance: ❑ Inject 100 mg subq every 4 weeks Qty: 1 box (1 x 100 mg/1 mL) ❑ SmartJet™ ❑ PFS		Refills: _____
Entyvio ®	Starter ❑ Infuse 300 mg in 250 ml NS; IV over 30 minutes at weeks 0, 2, and 6. Maintenance: ❑ Infuse 300mg in 250 ml NS IV; every 8 weeks Quantity #1 300 mg vial		Refills: _____
Stelara ®	❑ Infuse 260mg IV over no less than one hour (<55kg) 2 x 130 mg/26ml Vials ❑ Infuse 390mg IV over no less than one hour (>55kg) 3 x 130 mg/26ml Vials ❑ Infuse 520mg IV over no less than one hour (>85kg) 4 x 130 mg/26ml Vials		
	❑ Inject 90 mg subq 8 weeks following initial IV dose, then every 8 weeks thereafter Date of last infusion:_____ 1 x 90mg/ml PFS		Refills: _____
Xeljanz ®	❑ Take 10mg by mouth twice daily for 8 weeks	60 x 10mg tablets	Refills: one
	❑ Take 10mg by mouth twice daily ❑ Take 5mg by mouth twice daily ❑ _____	60 x 10mg tablets 60 x 5mg tablets _____	Refills: _____

**Remicade and Tysabri are located on separate forms*

Injection Training Provided by: ❑ Physician's Office ❑ CoxHealth at Home ❑ Other: _____

Prescriber's Signature:_____ Date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the prior authorization process.