APEX SPECIALTY PHARMACY

GASTROENTEROLOGY

Phone: 855.257.2584 || Fax: 866.680.3539

Date _____

☐ NEW START

☐ Continuation, Start Date: _____

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: _____

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Eosinophilic Esophagitis

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION

Immunosuppressants	☐ 5-ASA ☐ Azathioprine ☐ Budesonide ☐ Mercaptopurine ☐ Mesalamine ☐ Prednisone ☐ Sulfasalazine	
Biologics	☐ Cimzia ☐ Entyvio ☐ Humira ☐ Remicade ☐ Rinvoq ☐ Simponi ☐ Skyrizi ☐ Stelara ☐ Xeljanz	
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:
☐ Dupixent	☐ 300mg Syringe ☐ 300mg Pen	☐ Inject 300mg Once Weekly	Refill:
☐ Humira Induction ☐ Biosimilar: *write in* _____	☐ 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 ☐ Biosimilar: *write in* _____	☐ 40mg/0.4ml PEN ☐ 40mg/0.4ml Syringe ☐ 80mg/0.8ml PEN	☐ Inject 40mg SQ every-other-week ☐ Inject 80mg SQ every ____ week(s)	Refill:
☐ Rinvoq	☐ 15mg Tablet ☐ 30mg Tablet ☐ 45mg Tablet	☐ Start: 45mg once daily: ☐ 8 weeks ☐ ____ weeks ☐ Maint: ☐ 15mg once daily ☐ 30mg once daily	Refill: Refill:
☐ Skyrizi	☐ 180mg Cartridge ☐ 360mg Cartridge	☐ Inject _____mg with OBI at Week 12 then Every 8 Weeks *** Loading Dose Infusion was Started on Date: _____	Refill:
☐ Simponi Induction	☐ 100mg Syringe ☐ 100mg SmartJect	☐ Inject 200mg SQ at week 0, then 100mg at week 2	Refill: 0
☐ Simponi Maintenance	☐ 100mg Syringe ☐ 100mg SmartJect	☐ Inject 100mg every 4 weeks	Refill:
☐ Stelara	☐ 130mg Vial (Start) ☐ 90mg Syringe (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 ☐ Maint: ☐ 5mg twice daily ☐ 10mg twice daily	Refill: 0 Refill:

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN