

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address		City, State	Zip
Date of Birth		... / /	
Shipping Address (if different from home address)	Ship to MD	Home Phone Number ()	Work Phone Number ()

INSURANCE INFORMATION

(fill out entirely or fax a copy of patient's insurance card, both sides)

Primary Insurance	Secondary Insurance
Policy Number	Policy Number
Group Number	Group Number

MEDICAL INFORMATION

Diagnosis: Crohn's Disease Ulcerative Colitis Other _____ Date of Diagnosis _____ See Attached

Start Date _____ Review Date (within 6 months of start date) _____

Height _____ In Kg Weight _____ Lbs Kg Date of Measurement _____ See Attached

History of:
Multiple Sclerosis or Demyelinating Neurological Disease ACHF Tuberculosis Active Infection Other _____ See Attached

Current Medications _____ See Attached

Allergies _____ NKDA

Previous treatment with
Sulfasalazine Corticosteroid Mesalamine Products Immunosuppressants Remicade
Other _____ Dates of Therapy _____ See Attached

If previously treated; reason for discontinuation or retreatment: _____ See Attached

PRESCRIPTION INFORMATION

Cimzia 200mg PFS OR Cimzia 200mg Vial Enroll in CIMplicity® Initial Dose: Inject 400mg (2 PFS/vial) SQ at 0,2 and 4 weeks followed by: Maintenance Dose: Inject 400mg (2 PFS/vial) SQ every _____ Qty _____ Refill x _____	Humira 40mg Pen Crohn's Disease Starter Package Humira 40mg PFS OR Humira 40mg Pen Starter Pack: Inject 160mg (4 Pens) SQ on Day 1 Inject 80mg (2 Pens) SQ on Day 15 Inject 40mg (1 Pen) SQ on Day 28 Maintenance Dose: Inject 40mg (one pen/PFS) SQ every other week Qty _____ Refill x _____
Remicade 100mg Vial _____ mg/kg IV at 0, 2 and 6 weeks, then every _____ weeks thereafter Qty _____ Refill x _____	Other Directions: Qty _____ Refill x _____

PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number ()
Address		City, State	Zip
Date of Birth		... / /	
Today's Date	Date Needed By	DEA	On File
NPI		On File	

I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.

Prescriber's Signature

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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