Faxed prescription will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Crohn's / GI / UC Prescription Referral Form

1403 Highway 6 Suite 700A, Sugar Land, TX 77478 **Phone: 832.944.6112** **Fax: 832.944.6116**

Choice Infusion Center "Infuse to better health"

Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** _____ Male _____ Female **Height:** _____ **Weight:** _____ lbs. _____ kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (prescription and medical)

Prescriber Information

Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone: (_____) _____ - _____** **Fax: (_____) _____ - _____**

City: _____ **State:** _____ **Zip:** _____ **Key Contact:** _____ **Phone: (_____) _____ - _____**

Diagnosis/Clinical Information

Please FAX recent clinical notes, Labs, Tests, with the prescription to expidite the Prior Authorization

Diagnosis: _____ **ICD-9:** _____

Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
__ **Cimzia®**	__ Prefilled Syringes (2x200mg) (or) __ Lyophilized vials (2x200mg)	**Induction Dose:** __ Inject 400mg SC at weeks 0, 2, and 4 **Maintenance Dose:** __ 400mg SC every 4 weeks	_____	_____
__ **Humira®** Injection training from My Humira ***(patient must sign below)***	__ 20mg Pen __ 20mg Prefilled Syringe __ 40mg Pen __ 40mg Prefilled Syringe __ Starter Pack	**Induction Dose:** __ Inject 160mg SC (four 40mg Pens) for first dose (Day 1). Then inject 80mg SC (two 40mg Pens) two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29). **Maintenance Dose:** __ Inject 40mg SC (one 40mg Pen) every OTHER week	_____ _____	_____
__ **Xifaxan®**	__ 200mg tabs __ 550mg tabs	Take _____tablets _____ times per day		
__ **Remicade®**	__ 100mg Smartject __ 100mg Prefilled Syringe	**Induction Dose:** __ IV at 5mg/kg (Dose=_____mg) at 0, 2, and 6 weeks. **Maintenance Dose:** __ IV at 5mg/kg (Dose= _____mg) every 8 weeks. **Other:** _____		
__ **Simponi®** (Mycophenolic Acid)	__ 180mg __ 360mg	**Induction Dose:** __ Inject 200mg SC at week 0, then 100mg at week 2, then start maintenance at week 6 **Maintenance Dose:** __ 100mg SC every 4 weeks starting at week 6, after induction dose.	3 1	_____ _____

Date Medication Needed: ____/____/_____ **Ship To:** ____ Patient's Home _____ Prescriber's Office _____ Pick-up (store location): _____ Injection Training by Pharmacy

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: **Date:**

Prescriber Signature: Prescriber, please sign and date below

Dispense as written **Date:** **Substitution Permissable** **Date**

# of Prescriptions: _____