Ulcerative Colitis or Crohn's Disease

☐ New Patient

believeRX

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Patient Information

Patient Name	DOB:	Sex: ☐ male ☐ female	SSN:
Address	Weight: _____ ☐ kg ☐ lbs.	Height: _____ ☐ cm ☐ in	
City, State, zip	Phone:	Allergies:	

Clinical Information

Diagnosis: ☐ K50.0 (Crohn's Disease of the **Small** Intestine) ☐ K50.1 (Crohn's Disease of the **Large** Intestine) ☐ K50.8 (Crohn's Disease of **Both** Intestines) ☐ K50.9 (Crohn's Disease, unspecified)
☐ K51.0 (Ulcerative Pancolitis) ☐ K51.2 (Ulcerative Procolitis) ☐ K51.3 (Ulcerative Recto sigmoiditis) ☐ K51.5 (Left sided colitis) ☐ K51.8 (Other Ulcerative Colitis)
☐ K51.9 (Ulcerative Colitis, unspecified) ☐ Other: _____

Diagnosis Date_____ TB Test ☐ yes ☐ no Negative test date_____

Prior History: ☐ 5-ASA
☐ Immunosuppressants (6-MP or other)
☐ Corticosteroids
☐ Methotrexate
☐ Surgery
☐ Other _____

☐ Remicade®
☐ Humira®
☐ Cimzia®
☐ Other _____

Date of Last Dose:
_____
_____
_____
_____

Comorbidities _____ Concomitant Medications_____

Prescription Information

		Quantity	Refills
☐ **Cimzia®**(certolizumab) ☐ Enroll in Cimzia®Connect	☐ Inject 400mg sub-q at weeks 0,2 and 4 ☐ Inject 400mg sub-q every 4 weeks	☐ #6 x 200mg/ml ☐ #2 X 200mg/ml	☐PFS ☐Vials
☐ **Entyvio®**(vedolizumab) ☐ Enroll in EntyvioConnect	☐ 300mg infused intravenously over 30 minutes at 0, 2, 6 weeks, then every 8 weeks thereafter	☐ 3 Vials ☐ 1 vial	
☐ **Humira®**(adalimumab) Adults ☐ Enroll in Humira®Complete	☐ Inject 160mg sub-q on day 1, then 80mg on day 15 ☐ ☐ Inject 40mg sub-q on day 29 and every other week thereafter	☐ #3 x 80mg/0.8ml. ☐ #6 x 40mg/0.8ml ☐ ☐ #2 x 40mg/0.4ml ☐ #2 x 40mg/0.8ml	☐ Citrate Free Starter Kit Pens ☐ Starter Kit Pens ☐ ☐ Citrate Free PFS ☐ Citrate Free Pens ☐ PFS ☐ Pens
☐ Humi**ra®**(adalimumab) Pediatrics ≥6 years ☐ Enroll in Humira®Complete	☐ Starter dose: Inject 80mg sub-q day 1, then 40mg on day 15 (17<40kg) ☐ Starter dose: Inject 160mg sub-q day 1, then 80mg on day 15 (≥40kg) ☐ Maintenance dose: Inject 20mg sub-q on day 29 and every other week thereafter (17 to <40kg) ☐ Maintenance dose: Inject 40mg sub-q on day 29 and every other week thereafter (≥40kg)	☐ 1 x 80mg/0.8ml + 1 x 40mg/0.4ml ☐ 3 x 40mg/0.8ml ☐ 3 x 80mg/0.8ml ☐ 6 x 40mg/0.8ml ☐ 2 x 20mg/0.2ml ☐ 2 x 20mg/0.4ml ☐ 2 x 40mg/0.4ml ☐ 2 x 40mg/0.8ml	☐ Citrate Free Starter Kit PFS ☐ Starter Kit PFS ☐ Citrate Free Starter Kit PFS ☐ Starter Kit PFS ☐ Citrate Free PFS ☐ PFS ☐ Citrate Free PFS ☐ Citrate Free Pens ☐ PFS ☐ Pens
☐ **Remicade®**(Infliximab) ☐ Inflectra ☐ Renflexis ☐ Enroll in Care Path®	☐ Starter Dose: 5mg/kg IV at weeks 0, 2, and 6 ☐ Maintenance Dose: 5mg/kg IV every 8 weeks ☐ Other:	☐ _____ 100mg Lyophilized Vials (LYO) ☐ _____100mg Lyophilized Vials (LYO)	
☐ **Simponi®**(golimumab) ☐ Enroll in Janssen Care Path	☐ Inject 200mg sub-q at week 0, then 100mg at week 2 ☐ Inject 100mg sub-q every 4 weeks	☐ 3 x 100mg/ml ☐ 1 x 100mg/ml	☐ Smartject®Autoinjector ☐ PFS
☐ **Stelara®**(ustekinumab) ☐ Enroll in Care Path®	☐ Infuse 260mg Intravenously over no less than one hour (≤55kg) ☐ Inject 390mg intravenously over no less than one hour (>55kg to <85kg) ☐ Inject 520mg intravenously over no less than one hour (>85kg) ☐ Inject 90mg sub-q 8 weeks following initial intravenous dose, then every 8 weeks thereafter ☐ Date of last infusion:	☐ 2 X 130ng/26ml ☐ 3 x 130mg/26ml ☐ 4 x 130mg/26ml ☐ 1 x 90mg/ml	☐ Vials ☐ PFS
☐ **Uceris®**(Budesonide)	☐ Take 9mg by mouth once daily	☐ #30 x 9mg tablets	
☐ **Xeljanz®**(tofacitinib) ☐ Enroll in Xelsource	☐ Take 10mg by mouth twice daily for 8 weeks ☐ Take 10mg by mouth twice daily ☐ Take 5mg by mouth twice daily	☐ #60 X 10mg tablets ☐ #60 x 5mg tablets ☐	

Prescriber Information

Prescriber Name NPI DEA Phone#

Address City, State, zip Fax#

Injection training provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other _____

Per state law, prescriptions will be dispensed as generic, unless noted as Brand Name Medically Necessary here:_____

Stamp signature not allowed; physician signature required

Physicians Signature:_____ Date: _____

I authorize BelieveRX 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 BelieveRX.

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