

1950 Sand Lake Road, Bldg 5 Orlando, FL 32809

Phone: 855-797-8254 Fax: 863-413-5723

Patient Informatio						
	ie:					
	_//					
	1 ()					
Primary Phone Number: ()				er: () Using Cover My Me		
			-	-		
	Diagnosis:	Cronn's Disease	Olcerative Colitis			
Treatment status:				Weight: □ kg		
	☐ Continuation of therapy, sta	rt date:/	/	Height: \square cm	□ in	
Previously denied b	by insurance? ☐ No ☐ Yes, in	clude copy of deni	ial letter	Is the patient on sample	es? 🗆 No 🗆 Yes	
TB test results (wit	hin 6 months): □ N/A □ Nega	tive Dositive, Da	ate of TB test:			
Allergies: □ NKD	A 🗆 Other:					
	ment dates, and reason for disc					
MEDICATION	DOSE/STRENGTH		DIRECTION	ıs	DISPENSE	REFILLS
MEDICATION	DOSE/STRENGTH		BINECTION		QTY/DAYS	KEITELS
	☐ Starter Kit: 200 mg/mL					
	pre-filled syringe (PFS)	Initial Dose:			3 doses	0
	□ 200 ma viol	Inject 400 mg (2	3 doses	U		
□ Cimzia	□ 200 mg vial					
(certolizumab)						
	□ 200 mg/mL PFS	Maintenance Dos			□ 28 days □ 84 days	
	□ 200 mg vial	Inject 400 mg (2	ject 400 mg (2 x 200 mg) SC every 4 weeks			
		Initial Dose:				
	300 mg vial		g IV over 30 min on o	2 doses	0	
□ Entyvio						
(vedolizumab)		Maintenance Dos				
		Infuse 300 mg IV over 30 min every 8 weeks starting on day 43			56 days	
	□ SWFI 5 mL vial	Use 4.8 mL to reconstitute Entyvio vial before dilution			QS	PRN
Prescriber Informa	Ship to prescriber:	Never Always	First fill only		Appointment date:	//_
Name:			DEA#	NPI #		
Supervising Physic	ian: Not Applicable			Supervising Physician N	NPI #	
Address:			City:	State:	Zip:	
Office Phone Num	ber: ()	Fax Number:	: ()	Office Contact:		
I authorize Publix I	Pharmacy representatives to ac	t on behalf of the p	prescriber to initiate a	and complete the insuran	ce prior authorization	process.
Prescriber's signature:					For states requiring ha expressions to prevent	
(stamps not accepted)	☐ Substitution allowed	Date	Dienanca on wwitten/D-	ot substitute Dete	tion, write here:	. ธนบธนเน-
	Substitution allowed	Date	Dispense as written/ Do n	ot substitute Date		



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Patient Informatio				=		
Patient's First Name: Date of Birth:/ Male Female		Patient's Last Name:				
-	mber: ()		_			
Clinical Information [Attach copy of labs and clinical notes]				Using Cover My Med		
	Diagnosis:	Crohn's Disease	Ulcerative Colitis	Other:		
Treatment status:	□ New to therapy			Weight: \square kg \square	lb	
	☐ Continuation of therapy, sta	rt date:/	/	Height: \square cm	□ in	
Previously denied b	oy insurance? ☐ No ☐ Yes, ir	clude copy of denia	al letter	Is the patient on samples	? □ No □ Yes	
TB test results (wit	hin 6 months): □ N/A □ Nega	tive □ Positive, Da	te of TB test:	/ /		
	A □ Other:					
	ment dates, and reason for disc					
Ther merupy, treat	ment dates, and reason for disc					
MEDICATION	DOSE/STRENGTH		DIRECTIONS		DISPENSE QTY/DAYS	REFILLS
	☐ Start Kit: 3 x 80mg/0.8mL					
	pen (CF)	Initial Dose:			28 days	
	Ctart Vity 6 v 10mm a/0 0mm		C on day 1, then 80 i		(1 kit)	0
	☐ Start Kit: 6 x 40mg/0.8mL pen	inject 80 mg SC	on days 1, 2, and 15)		
☐ Humira	•					
(adalimumab)						
	□ 40 mg/0.4 mL pen (CF)	Maintenance Dose	e (starting on day 29)):		
	□ 40 mg/0.4 mL PFS (CF)	☐ Inject 40 mg SC	every other week	•	□ 28 days	
	□ 40 mg/0.8 mL pen	☐ Inject 40 mg SC	C every week			
	\square 40 mg/0.8 mL PFS	Utner:				
		Initial Dose:				
□ Remiçade		Infual Dose: ☐ Infuse	mg (mg/kg)	IV over at least 2 hours	3 doses	0
(infliximab)		on days 1, 15, a				
☐ Avsola (infliximab-axxq)	100 mg vial					
☐ Inflectra (infliximab-dyyb)		Maintenance Dose	·:			
□ Renflexis		☐ Infusemg (mg/kg) IV over at least 2 hours 1 dose				
(infliximab-abda)		every we	eks			
Pt wt:	□ SWFI 10ml vials	Use 10ml per vial	to reconstitute inflix	imab before dilution	QS	PRN
Prescriber Informat	tion [Ship to prescriber: N	lever Always	First fill only	A	ppointment date:	/ /
Name:		·	DEA#	NPI #		
Supervising Physici				Supervising Physician NP		
Address:				State:		
Office Phone Numb				Office Contact:		
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Prescriber's signature: expressions to prevent subst (stamps not accepted) tion, write here:					substitu-	
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Allergies: □ NKD	A 🗆 Other:					
	ment dates, and reason for disc					
					DICPENCE	
MEDICATION	DOSE/STRENGTH		DIRECTIONS		DISPENSE QTY/DAYS	REFILLS
☐ Rinvoq (upadacitinib)	□ 45 mg tablet	Initial Dose: Take 1 tab PO one time daily for 56 days			28 days	1
	□ 15 mg tablet □ 30 mg tablet	Maintenance Dose Take 1 tab PO one	aintenance Dose: ake 1 tab PO one time daily starting on day 57			
☐ Simponi (golimumab)	□ 100 mg/mL SmartJect	Initial Dose: ☐ Inject 200 mg (2 x 100 mg) SC on day 1			1 dose	0
	□ 100 mg/mL PFS	Maintenance Dose: □ Inject 100 mg SC every 4 weeks starting on day 15			□ 28 days □ 84 days	
□ Skyrizi	600 mg/ 10 mL vial	Initial Dose: Infuse 600 mg IV over at least 1 hour on weeks 0, 4 and 8			3 doses	0
(risankizumab)	360 mg/ 2.4 mL OBI	Maintenance Dose: Inject 360 mg SC every 8 weeks starting on week 12			1 dose	
☐ Stelara (ustekinumab)	130 mg vial	☐ 56-85 kg: Infuse	Initial Dose: □ ≤ 55 kg: Infuse 260 mg IV over at least 1 hour on day 1 □ 56-85 kg: Infuse 390 mg IV over at least 1 hour on day 1 □ >85 kg: Infuse 520 mg IV over at least 1 hour on day 1 Maintenance Dose: Inject 90 mg SC every 8 weeks			0
Pt wt:	90 mg/mL PFS					
Prescriber Informa	tion [Ship to prescriber: N	lever Always	First fill only		Appointment date:	//_
Name:				NPI #		
	ian: Not Applicable					
			City:	State:	Zip:	
	per: ()					
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	ment dates, and reason for disc					
					DICPENCE	
MEDICATION DOSE/STRENGTH			DIRECTIONS	5	DISPENSE QTY/DAYS	REFILLS
		Initial Dose:				□ 1
	□ 10 mg tablet		ce a day for up to 4 i	30 days	□ 2 □ 2	
□ Xeljanz						□ 3
(tofacitinib)						
	☐ 10 mg tablet☐ 5 mg tablet☐	Maintenance Dose Take 1 tab PO twice			□ 30 days □ 90 days	
	3 mg tablet	Tune Tune To twi	ee a aay	□ 90 days		
						□ 1
	☐ 22 mg tablet XR	Initial Dose: Take 1 tab PO one	time daily for up to	4 months	30 days	\square 2
□ Xeljanz XR			,			□ 3
(tofacitinib)	= 00				= 20.1	
	☐ 22 mg tablet XR ☐ 11 mg tablet XR	Maintenance Dose Take 1 tab PO one			□ 30 days □ 90 days	
	IT mg moret Are			= 50 days		
		1 % 1D				
	Starter Kit	Initial Dose: Take 0.23 mg PO	one time daily on da	ys 1 through 4, 0.46 mg	1 kit	0
		one time daily on o	days 5 through 7, the	en 0.92 mg once daily		
☐ Zeposia (ozanimod)						
(ozaminou)						
	0.92 mg capsules	Maintenance Dose Take 1 cap PO one	(starting on day 8):		30 days	
		time daily				
Prescriber Informati	tion [Ship to prescriber: N	lever Always	First fill only		Appointment date:	/ /
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	an: Not Applicable					
				State:		
Address: Ci Office Phone Number: () Fax Number: ()						
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Prescriber's signature: (stamps not accepted)					expressions to prevent substitu-	
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