Publix Specialty Pharmacy (#3213)

CROHN'S DISEASE/ULCERATIVE COLITIS (FORM A)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: ____/____/_____ ☐ Male ☐ Female Caregiver Name: _____

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

Primary Phone Number: (____) _____ Alt. Phone Number: (____) _____

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: _____ Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other: _____

Treatment status: ☐ New to therapy Weight: _____ ☐ kg ☐ lb

☐ Continuation of therapy, start date: ____/____/_____ Height: _____ ☐ cm ☐ in

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Is the patient on samples? ☐ No ☐ Yes

TB test results (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: _____/_____/_____

Allergies: ☐ NKDA ☐ Other: _____

Prior therapy, treatment dates, and reason for discontinuation: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Cimzia (certolizumab)	☐ Starter Kit: 200 mg/mL pre-filled syringe (PFS) ☐ 200 mg vial	Initial Dose: Inject 400 mg (2 x 200 mg) SC on days 1, 15, and 29	3 doses	0
	☐ 200 mg/mL PFS ☐ 200 mg vial	Maintenance Dose: Inject 400 mg (2 x 200 mg) SC every 4 weeks	☐ 28 days ☐ 84 days	_____
☐ Entyvio (vedolizumab)	300 mg vial	Initial Dose: ☐ Infuse 300 mg IV over 30 min on days 1 and 15	2 doses	0
		Maintenance Dose: ☐ 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 Information [Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ___/___/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable ☐ _____ Supervising Physician NPI # _____

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

Office Phone Number: (____) _____ Fax Number: (____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted)

_____ ☐ Substitution allowed Date

_____ ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

Publix Specialty Pharmacy (#3213)

CROHN'S DISEASE/ULCERATIVE COLITIS (FORM B)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name: _____

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

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information [Attach copy of labs and clinical notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: _____ Diagnosis: ☐Crohn's Disease ☐Ulcerative Colitis ☐Other: _____

Treatment status: ☐New to therapy Weight: _____ ☐kg ☐lb

☐Continuation of therapy, start date: _____/_____/_____ Height: _____ ☐cm ☐in

Previously denied by insurance? ☐No ☐Yes, include copy of denial letter Is the patient on samples? ☐No ☐Yes

TB test results (within 6 months): ☐N/A ☐Negative ☐Positive, Date of TB test: _____/_____/_____

Allergies: ☐NKDA ☐Other: _____

Prior therapy, treatment dates, and reason for discontinuation: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐Humira (adalimumab)	☐Start Kit: 3 x 80mg/0.8mL pen (CF) ☐Start Kit: 6 x 40mg/0.8mL pen	Initial Dose: ☐Inject 160 mg SC on day 1, then 80 mg on day 15 ☐Inject 80 mg SC on days 1, 2, and 15	28 days (1 kit)	0
	☐40 mg/0.4 mL pen (CF) ☐40 mg/0.4 mL PFS (CF) ☐40 mg/0.8 mL pen ☐40 mg/0.8 mL PFS	Maintenance Dose (starting on day 29): ☐Inject 40 mg SC every other week ☐Inject 40 mg SC every week ☐Other: _____	☐28 days ☐84 days	_____
☐Remicade (infliximab) ☐Avsola (infliximab-axxq) ☐Inflectra (infliximab-dyyb) ☐Renflexis (infliximab-abda)	100 mg vial	Initial Dose: ☐Infuse _____mg (_____mg/kg) IV over at least 2 hours on days 1, 15, and 43	3 doses	0
		Maintenance Dose: ☐Infuse _____mg (_____mg/kg) IV over at least 2 hours every _____ weeks	1 dose	_____
Pt wt: _____	☐ SWFI 10ml vials	Use 10ml per vial to reconstitute infliximab before dilution	QS	PRN

Prescriber Information [Ship to prescriber: ☐Never ☐Always ☐First fill only Appointment date: ___/___/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐Not Applicable ☐ _____ Supervising Physician NPI # _____

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

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

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Publix Specialty Pharmacy (#3213)

CROHN'S DISEASE/ULCERATIVE COLITIS (FORM C)

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Phone: 855-797-8254
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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name: _____

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

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information [Attach copy of labs and clinical notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: _____ Diagnosis: ☐Crohn's Disease ☐Ulcerative Colitis ☐Other: _____

Treatment status: ☐New to therapy Weight: _____ ☐kg ☐lb

☐Continuation of therapy, start date: _____/_____/_____ Height: _____ ☐cm ☐in

Previously denied by insurance? ☐No ☐Yes, include copy of denial letter Is the patient on samples? ☐No ☐Yes

TB test results (within 6 months): ☐N/A ☐Negative ☐Positive, Date of TB test: _____/_____/_____

Allergies: ☐NKDA ☐Other: _____

Prior therapy, treatment dates, and reason for discontinuation: _____

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 time daily starting on day 57	30 days	_____
☐Simponi (golimumab)	☐100 mg/mL SmartJect ☐100 mg/mL PFS	Initial Dose: ☐Inject 200 mg (2 x 100 mg) SC on day 1	1 dose	0
		Maintenance Dose: ☐Inject 100 mg SC every 4 weeks starting on day 15	☐28 days ☐84 days	_____
☐Skyrizi (risankizumab)	☐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
	☐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	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	1 dose	0
Pt wt: _____	☐90 mg/mL PFS	Maintenance Dose: Inject 90 mg SC every 8 weeks	56 days	_____

Prescriber Information [Ship to prescriber: ☐Never ☐Always ☐First fill only Appointment date: ___/___/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable ☐ _____ Supervising Physician NPI # _____

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

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CROHN'S DISEASE/ULCERATIVE COLITIS (FORM D)

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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name: _____

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

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information [Attach copy of labs and clinical notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: _____ Diagnosis: ☐Crohn's Disease ☐Ulcerative Colitis ☐Other: _____

Treatment status: ☐New to therapy Weight: _____ ☐kg ☐lb

☐Continuation of therapy, start date: _____/_____/_____ Height: _____ ☐cm ☐in

Previously denied by insurance? ☐No ☐Yes, include copy of denial letter Is the patient on samples? ☐No ☐Yes

TB test results (within 6 months): ☐N/A ☐Negative ☐Positive, Date of TB test: _____/_____/_____

Allergies: ☐NKDA ☐Other: _____

Prior therapy, treatment dates, and reason for discontinuation: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐Xeljanz (tofacitinib)	☐10 mg tablet	Initial Dose: Take 1 tab PO twice a day for up to 4 months	30 days	☐1 ☐2 ☐3
	☐10 mg tablet ☐5 mg tablet	Maintenance Dose: Take 1 tab PO twice a day	☐30 days ☐90 days	_____
☐Xeljanz XR (tofacitinib)	☐22 mg tablet XR	Initial Dose: Take 1 tab PO one time daily for up to 4 months	30 days	☐1 ☐2 ☐3
	☐22 mg tablet XR ☐11 mg tablet XR	Maintenance Dose: Take 1 tab PO one time daily	☐30 days ☐90 days	_____
☐Zeposia (ozanimod)	☐Starter Kit	Initial Dose: Take 0.23 mg PO one time daily on days 1 through 4, 0.46 mg one time daily on days 5 through 7, then 0.92 mg once daily	1 kit	0
	☐0.92 mg capsules	Maintenance Dose (starting on day 8): Take 1 cap PO one time daily	30 days	_____

Prescriber Information [Ship to prescriber: ☐Never ☐Always ☐First fill only Appointment date: ___/___/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐Not Applicable ☐ _____ Supervising Physician NPI # _____

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