Publix Specialty Pharmacy #3213
CROHN'S DISEASE/ULCERATIVE COLITIS

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

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

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

CLINICAL INFORMATION [Attach copy of labs and clinical notes]

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

Treatment status: ☐New to therapy ☐Continuation of therapy, start date: ___/___/_____

Previously denied by insurance? ☐No ☐Yes, include copy of denial letter

Is the patient on samples? ☐No ☐Yes

Weight: _____ ☐kg ☐lb

Height: _____ ☐cm ☐ in

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 pegol)	☐Starter Kit: 6 x 200 mg/mL pre-filled syringe (PFS) ☐200 mg vial	Initial Dose: Inject 400 mg SC on days 1, 15, and 29	3 doses (6 PFS/vials)	0
	☐200 mg/mL PFS ☐200 mg vial	Maintenance Dose: Inject 400 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	_____
	☐Sterile water for inj 5 mL vial ☐Sodium chloride 0.9% inj 250 mL bag	Use 4.8 mL to reconstitute Entyvio vial before dilution Dilute reconstituted Entyvio into 250 mL of NS	QS	_____
☐ Humira (adalimumab)	☐Starter Kit: 3 x 80 mg/0.8 mL pen (citrate-free) ☐Starter Kit: 6 x 40 mg/0.8 mL 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 (citrate-free) ☐40 mg/0.8 mL pen ☐40 mg/0.4 mL PFS (citrate-free) ☐40 mg/0.8 mL PFS	Maintenance Dose (starting on day 29): ☐Inject 40 mg SC every 2 weeks ☐Other: _____	☐28 days ☐84 days	_____
☐ Simponi (golimumab)	☐100 mg/mL SmartJect ☐100 mg/mL PFS	Initial Dose: ☐Inject 200 mg SC on day 1	1 dose (2 pens/PFS)	0
		Maintenance Dose: ☐Inject 100 mg SC every 4 weeks starting on day 15	☐28 days ☐84 days	_____
☐ Stelara (ustekinumab)	☐130 mg vial Patient weight: _____	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
	☐Sodium chloride 0.9% inj 250 mL bag	Dilute total volume of Stelara to a final volume of 250 mL	QS	0
	☐90 mg/mL PFS	Maintenance Dose (starting on day 57): Inject 90 mg SC every 8 weeks	56 days	_____
☐ Xeljanz (tofacitinib)	☐22 mg tablet XR	Initial Dose: Take 1 tab PO daily with or without food for ≥8 weeks	30 days	☐1 ☐2 ☐3
	☐10 mg tablet	Take 1 tab PO BID with or without food for ≥8 weeks		
	☐22 mg tablet XR ☐11 mg tablet XR	Maintenance Dose: Take 1 tab PO daily with or without food	☐30 days ☐90 days	_____
	☐10 mg tablet ☐5 mg tablet	Take 1 tab PO BID with or without food		

PRESCRIBER INFORMATION [Ship to prescriber: ☐ Never ☐Always ☐First fill only, appointment date: ___/___/_____ Using Cover My Meds: ☐No ☐Yes]

Name: _____ DEA# _____ 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: