Crohn's Disease
Prescription &
Pharmacy Intake Form

Phone: 1-718-762-7400
Fax: 1-718-762-7404
Toll Free: 1-888-93-EVERS

Provider Representative | **Phone** **Date Needed** **Ship to** ☐ Specialty Care Center ☐ Patient's Home ☐ Prescriber's Office ☐ Other____________

PATIENT INFORMATION

Patient Name: ____________ DOB: ________ ☐ Male ☐ Female
Address: ____________
City: ____________ State: ______ Zip Code: ________
Phone # (Daytime): ____________ Phone # (Evening): ____________
E-mail Address: ____________ Case Manager: ________
Insurance Provider (**Please include copy of front and back of card**): ____________
ID #: ________ Policy/Group #: ________ Phone #: ________
Name of Insured: ____________ Employer: ____________
Relationship to Patient: ☐ Self ☐ Other: ________ ☐ Patient is Eligible for Medicare
Prescription Card: ☐ Yes ☐ No Carrier: ________ Policy/Group #: ________
Will there be access to anaphylactic medications and oxygen at the administration site? ____________

CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Patient is Currently on Therapy
(Start Date: ________)
☐ Physician Provides Injection Training
Injection/Infusion Date: ________

Primary ICD-9 Code and Condition:
____

Other ICD-9/Conditions:
____

Date of Diagnosis: ________
Current Weight: ______ Date: ______
TB Test Results & Date: ________

☐ New Therapy Induction ☐ Therapy Change
☐ Remicade® Therapy Continuation
Weeks Completed ☐ 0 ☐ 2 ☐ 6
Stop Date: ________

☐ Inadequate Response to Methotrexate (Dose: ______)
☐ Unresponsive to Conventional Treatment
Other Therapies Tried & Failed (Please List):
____
Allergies: ____________

PRESCRIPTION INFORMATION

Medication	Dose/Directions/Freq	Qty	Refills
Cimzia® **(certolizumab pegol)** ☐ 2 x 200 mg kit ☐ Prefilled Syringe ☐ Vial			
Humira® **(adalimumab)** ☐ Starter Kit (6) 40 mg Pens ☐ 40 mg Pre lled Syringe ☐ 40 mg Pen			
Remicade® **(infliximab)** ☐ 100 mg Vial			
☐ Other: ________			
☐ Other: ________			

PRESCRIBER INFORMATION

Prescriber's Name: ____________ Practice/Facility Name: ____________
Address: ____________ Office Contact: ____________
City: ____________ State: ______ Zip Code: ________
Phone #: ____________ Fax: ____________ Best Time to Call: ________
State License #: ________ DEA #: ________ NPI#: ________ Medicaid UPIN #: ________
In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**," or your state speci c required language to prohibit substitution: ____________
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.
Prescriber's Signature Required: ____________ Date: ________

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.
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Drug names are the property of their respective owners.