



1. Patient Information

Patient Name: _____ SSN: _____ DOB: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Email Address: _____
 Sex: Male Female Height: _____ Weight: lbs. kg. Known Allergies: _____

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis: _____ ICD 10: _____

4. Prescription Information: For IV medications attach a copy of your prescription

Medication	Dose/Strength	Sig/Directions	Quantity	Refills
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Prefilled Syringes (2x200mg) (or) <input type="checkbox"/> Lyophilized vials (2 x 200mg)	Starter Dose: <input type="checkbox"/> Inject 400mg SC at weeks 0, 2, and 4 Maintenance Dose: <input type="checkbox"/> 400mg SC every 4 weeks Other: <input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> Humira®	<input type="checkbox"/> 20mg/0.2mL Pen <input type="checkbox"/> 20mg/0.2mL Prefilled Syringe <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 40mg/0.4mL Prefilled Syringe <input type="checkbox"/> 80mg/0.8mL Pen <input type="checkbox"/> 80mg/0.8mL Prefilled Syringe <input type="checkbox"/> Starter Pack	Starter Dose: <input type="checkbox"/> Inject 160mg SC (four 40mg Pens) for first Dose (Day 1). Then Inject 80mg SC (two 40mg Pen) two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29). Maintenance Dose: <input type="checkbox"/> Inject 40mg SC (one 40mg Pen) every other week Other: <input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> Humira® Citrate-Free	<input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 40mg/0.4mL Prefilled Syringe <input type="checkbox"/> 80mg/0.8mL Pen <input type="checkbox"/> 80mg/0.8mL Prefilled Syringe <input type="checkbox"/> Starter Pack (3-80mg Pens)	Starter Dose: <input type="checkbox"/> Inject 160mg SC (two 80mg/0.8mL Pens) for first Dose (Day 1). Then Inject 80mg/0.8mL SC (one 80mg/0.8mL Pen) two weeks after first dose (Day 15). Then inject 40mg/0.4mL SC every OTHER week starting at week 4 (Day 29). Maintenance Dose: <input type="checkbox"/> Inject 40mg SC (one 40mg/0.4mL Pen) every other week	_____	_____
<input type="checkbox"/> Xifaxan®	<input type="checkbox"/> 200mg tabs <input type="checkbox"/> 550mg tabs	Take _____ tablets _____ times per day	_____	_____
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100mg vial		_____	_____
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100mg Smartlect® <input type="checkbox"/> 100mg Prefilled Syringe	Starter Dose: <input type="checkbox"/> Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 Maintenance Dose: <input type="checkbox"/> 100mg SC every 4 weeks starting at week 6, after Induction dose Other: <input type="checkbox"/> _____	3 1	_____
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300mg vial		_____	_____
<input type="checkbox"/> Dificid®	<input type="checkbox"/> 200mg tabs	<input type="checkbox"/> Take 1 tablet twice daily with or without food for 10 days	20 tablets	_____
<input type="checkbox"/> Stelara® Starter Dose	<input type="checkbox"/> 2x 130mg/26ml <input type="checkbox"/> 3x 130mg/26ml <input type="checkbox"/> 4x 130mg/26ml	</=55kg: <input type="checkbox"/> Infuse 260mg IV as induction dose over at least 1 hour >55kg to </=85kg: <input type="checkbox"/> Infuse 390mg IV as induction dose over at least 1 hour >85kg: <input type="checkbox"/> Infuse 520mg IV as induction dose over at least 1 hour Low-dose induction: <input type="checkbox"/> Infuse 130mg IV over at least 1 hour	_____ vials	_____
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 1x 90mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 90mg SC 8 weeks after initial IV dose and then every 8 weeks thereafter Other: <input type="checkbox"/> _____	1x90mg/ml PFS	_____

Ship to: Patient Office Other

5. Physician Information:

INJECTION TRAINING: Office to Instruct SP to Arrange Teaching

Prescriber Name: _____ Prescriber NPI: _____ DEA#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Office Contact: _____ Fax Number: _____ Phone Number: _____
 Office Contact Email: _____

Prescriber Signature: Prescriber, please sign and date below

*I authorize SafeScript Pharmacy and it's representatives to act as my authorized agent to secure coverage and initiate prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

Dispense as written Substitution Permissible

Prescriber's Signature _____ Date _____

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.