Community Memorial Pharmacy
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Gastroenterology (S-Z) Simponi®, Skyrizi®, Stelara®, Tremfya®, Velsipity™, Xeljanz®, Xeljanz® XR, Zeposia®, Zymfentra™

Prescriber Information

Prescriber Name _____ ☐ MD ☐ DO ☐ NP ☐ PA NPI _____

Office Contact _____ Practice Name / Collaborating MD _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name _____ Last 4 Digits of SS# _____ DOB / /

Sex ☐ M ☐ F Weight _____ Height _____ Diabetic? ☐ Y ☐ N

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell _____ HIPAA Contact _____

Emergency # _____

Interpreter Needed? ☐ Y ☐ N | Allergies ☐ Y ☐ N If Yes, list allergies _____

Insurance Information

Primary Insurance _____ Policy ID _____ Group# _____

BIN _____ PCN _____

Policyholder Name _____ Policyholder DOB / /

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

ICD-10/Diagnosis Code

Crohn's Disease ☐ K50.0 ____ (Crohn's of the Small Intestine) ☐ K50.1 ____ (Crohn's of the Large Intestine) ☐ K50.8 ____ (Crohn's of Both Intestines) ☐ K50.9 ____ (Crohn's, Unspecified)

Ulcerative Colitis ☐ K51.0 ____ (Ulcerative Pancolitis) ☐ K51.2 ____ (Ulcerative Procolitis)
☐ K51.3 ____ (Ulcerative Rectosigmoiditis) ☐ K51.5 ____ (Left Sided Colitis)
☐ K51.8 ____ (Other Ulcerative Colitis) ☐ K51.9 ____ (Ulcerative Colitis, Unspecified)
☐ K58.0 ____ (Irritable Bowel Syndrome with Diarrhea) ☐ Other _____

Date of Diagnosis / / Date of Negative TB Test / /

Prior Treatment? ☐ Y ☐ N (Provide Information Below)

Prior Therapy _____

Reason for Discontinuation of Therapy _____ Approx. Start Date / /
Approx. End Date / /

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **SIMPONI®** ☐ SmartJect ☐ PFS	☐ 3 cartons (100 mg/ml)	☐ Starter Dose: Inject 200 mg SQ at week 0; then 100 mg at week 2	No Refills
	☐ 1 carton (100 mg/ml)	☐ Maintenance Dose: Inject 100 mg SQ every 4 weeks, starting at week 6	
☐ **SKYRIZI®**	☐ 1 cartridge (360 mg/2.4ml) with on-body injector ☐ 1 cartridge (180 mg/1.2ml) with on-body injector	Maintenance Dose: ☐ Inject 360 mg SQ beginning at week 12, and every 8 weeks thereafter ☐ Inject 180 mg SQ beginning at week 12, and every 8 weeks thereafter	
☐ **STELARA®**	☐ 1 carton (1x90 mg/ml PFS)	☐ Maintenance Dose: Inject 1 ml (90 mg) SQ 8 weeks after infusion, then every 8 weeks thereafter	
☐ **TREMFYA®** ☐ PFS ☐ Pen	☐ CD Induction Pack (2x200 mg/ml PENS)	☐ CD Starter Dose: Inject 400 mg SQ at weeks 0, 4 and 8	2 Refills
	☐ 1 carton (1x100 mg/ml) ☐ 1 carton (1x200 mg/ml)	Maintenance Dose: ☐ Inject 100 mg SQ at week 16 and every 8 weeks thereafter ☐ Inject 200 mg SQ at week 12 and every 4 weeks thereafter	
☐ **VELSIPITY™**	☐ 2 mg tablets (30 day supply)	☐ Take 1 tablet by mouth once daily	
☐ **XELJANZ®**	☐ 10 mg tablets (quantity QS for length of starter dose therapy, in multiples of 60 tablets)	☐ Starter Dose: Take 10 mg by mouth twice daily for ___ weeks	No Refills
	☐ 5 mg tablets (30 day supply) ☐ 10 mg tablets (30 day supply)	☐ Maintenance Dose: Take 1 tablet by mouth two times a day	
☐ **XELJANZ® XR**	☐ 22 mg tablets (quantity QS for length of starter dose therapy, in multiples of 30 tablets)	☐ Starter Dose: Take 22 mg by mouth once daily for ____ weeks	No Refills
	☐ 11 mg tablets (30 day supply) ☐ 22 mg tablets (30 day supply)	☐ Maintenance Dose: Take 1 tablet by mouth once daily	

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **ZEPOSIA®**	☐ Starter Pack (7 day supply) ☐ Starter Kit (37 day supply)	☐ Take 0.23 mg by mouth daily on days 1-4, then 0.46 mg daily on days 5-7, then 0.92 mg daily thereafter	
	☐ 0.92 mg capsules (30 day supply)	☐ Maintenance Dose: Take 1 capsule by mouth daily	
☐ **ZYMFENTRA™** (infliximab-dyyb) ☐ PFS ☐ Pen	☐ 1 carton (2x120 mg/ml)	☐ Maintenance Dose: Inject 120 mg SQ every 2 weeks, starting at week 10	

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____
Substitution Permitted

Date _____

Prescriber Signature _____
Dispense as Written

Date _____

If brand is required, please write "DAW" in the box to the right. ☐