ADVOCATE PHARMACY

Phone: 215-362-2479
535 South Broad Street Lansdale PA 19446

Chron's

Prescription & Pharmacy Intake Form

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 #: _____

CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Patient is Currently on Therapy
(Start Date: _____)

Primary ICD-9 Code and Condition:
_____

Primary ICD-9 /Conditions:
_____

Date of Diagnosis: _____
Current Weight: _____ Date: _____
TB Test Results & Date: _____
☐ New Therapy Induction ☐ Therapy Change
☐ Remicade® Therapy Continuation
Weeks Completed ☐ 1 ☐ 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 Prefilled 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 Licenses #: _____ 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 specific 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: _____