

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) <input type="checkbox"/> 2 x 200 mg kit <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial			
Humira® (adalimumab) <input type="checkbox"/> Starter Kit (6) 40 mg Pens <input type="checkbox"/> 40 mg Prefilled Syringe <input type="checkbox"/> 40 mg Pen			
Remicade® (infliximab) <input type="checkbox"/> 100 mg Vial <input type="checkbox"/> Other: _____			
<input type="checkbox"/> 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: _____

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It bring-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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