Biologic Therapy

COREXA PHARMACY

354 Eagles Landing Drive,
Lakeland, FL 33810
TOLL FREE: (844) 277-4276
Phone: (727) 896-0001
Fax: (727) 896-0002

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____ Ethnicity: _____
Language: _____ Wt: _____ ☐ kg ☐ lbs Ht: _____ ☐ cm ☐ in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Bin: _____ PCN: _____
ID: _____ Group #: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription	Form/Strength/Directions For Use	Quantity	Refills
☐ **Xifaxan**	☐ 200 mg _____ mg po ☐ BID ☐ TID for ___ days ☐ 550 mg _____ mg po ☐ BID ☐ TID for ___ days		
☐ **Simponi**	☐ Initial Dosing: 200 mg SC week 0 then 100mg SC week 2 ☐ Other: ☐ Ongoing treatment: 100mg SC every 4 weeks ☐ Other:		
☐ **Cimzia** (200mg Vials for PFS)	☐ Lyophilized vial ☐ Pre-Filled Syringe ☐ Initial Dosing: 400mg SC at 0, 2, 4 weeks (ongoing treatment below) ☐ Ongoing treatment (after initial dosing): 400mg every 4 weeks		
☐ **Stelara**	☐ 45mg PFS SC x1 followed by 45mg PFS SC in 4 weeks (For patients weighing < 100kg) ☐ 90mg PFS SC x1 followed by 90mg PFS SC in 4 weeks (For patients weighing > 100kg) Maintenance Dosing: ☐ 45mg PFS SC every 12 weeks ☐ 90mg PFS SC every 12 weeks ☐ 260mg ☐ 390mg ☐ 520mg followed by ☐ 90mg IV every 8 weeks		
☐ **Humira** (Supplied as 40mg pens or as PFS)	☐ Initial Dosing: Chron's/Ulcerative Colitis Starter Pack - six 40mg single dose pens 160mg (four 40mg injections) SC x one dose (day 1) then 80mg SC x one two weeks later (day 15) ☐ Ongoing treatment: ☐ Pen or ☐ PFS 40mg SC every other week (Start 29 days after initial dosing) ☐ Other:		
☐ **Humira Pediatric** (Supplied as PFS)	**Initial dosing for children >/= 6 and >/= 40kg:** ☐ 4x40 mg inj SC on Day 1 then 2x40mg inj SC 2 weeks later on Day 15 (tray of 6) ☐ 2x40 mg inj SC on Days 1 and 2 then 2x40mg inj SC 2 weeks later on Day 15 (tray of 6) **Initial dosing for children >/= 6 and weighing 17kg to < 40kg:** ☐ 2x40 mg inj SC on Day 1 then 1x40mg inj SC 2 weeks later on Day 15 (tray of 3) **Maintenance:** ☐ 40mg SC every other week ☐ 20mg SC every other week		
☐ **Relistor**	☐ 150mg tab ☐ 8mg/0.4ml Sol'n for Inj ☐ 12mg/0.6ml Sol'n for Inj Sig: _____		
☐ **Other**			

Information Needed to Obtain Prior Authorization

Primary Diagnosis: ☐ ICD-10 ☐ Other: _____
Weight: _____ **pounds** **Allergies:** _____
Failed Therapies: _____ **Please provide current list of medications:** _____

***For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availability (or insurance preference) will be dispensed.*

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize Corexa Health Pharmacy and it's representatives to act as an agent to initiate and execute the insurance prior authorization and appeal process for this prescriptions and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice Corexa Pharmacy.