RELIANT HEALTHCARE

Gastroenterology
ORDER FORM

Phone: (877) 354-2688
Fax: (844) 635-5250

PATIENT INFORMATION

Name:
Address:
City: **State:** **ZIP:**
Phone: **Alt Phone:**
Email: **Caregiver:**
DOB: **Ht:** **Wt:** **Gender:** ☐ M ☐ F

PRESCRIBER INFORMATION

Name:
Address:
City: **State:** **ZIP:**
Phone: **Fax:**
NPI: **DEA:** **Tax ID:**
Office Contact: **Phone:**

CLINICAL INFORMATION

Diagnosis (ICD-10): ☐ K50.90 Crohn's disease ☐ K51.90 Ulcerative colitis ☐ K20.0 Eosinophilic esophagitis ☐ Other:
Drug Allergies: **Latex Allergy:** ☐ Yes ☐ No
TB/PPD Test Given? ☐ Yes (please send copy of results) ☐ No **Date:** **Result:**
Prior Failed Medications: ☐ Methotrexate ☐ Corticosteroids ☐ Azathioprine ☐ 5-ASA (Mesalamine) ☐ Sulfasalazine ☐ 6-Mercaptopurine ☐ Other:
Medication: **Length of Treatment:** **Reason for Discontinuing:**
Medication: **Length of Treatment:** **Reason for Discontinuing:**
Please Fax Copies: ☐ Medical card (front and back) ☐ Prescription card (front and back) ☐ Clinical notes

MEDICATION	DOSAGE AND STRENGTH	DIRECTIONS ☐ SHIP TO HOME ☐ IN OFFICE	QTY	REFILLS
☐ **Adalimumab***	☐ 40mg/0.4mL Pen CF	☐ **Starter Dose:** Inject 160mg SC on day 1, then 80mg SC on day 15	QS	None
	☐ 40mg/0.4mL Prefilled Syringe CF	☐ **Maintenance Dose:** Inject 40mg SC every other week starting day 29	QS	
	☐ DAW1 Product:	☐ **Maintenance Dose:** Inject 40mg SC once a week starting day 29	QS	
☐ **Cimzia**	☐ Starter Kit 200mg/mL	☐ **Starting Dose (Starter Kit):** Inject 400mg SC at week 0, 2 and 4	QS	None
	☐ 200mg/mL Prefilled Syringe	☐ **Maintenance Dose:** Inject 400mg SC every ☐ 2 weeks ☐ 4 weeks	QS	
☐ **Dupixent**	☐ 200mg/1.14mL ☐ Pen ☐ PFS	☐ **15 to <30 kg:** Inject 200mg SC every other week (Q2W)	QS	
	☐ 300mg/2mL ☐ Pen ☐ PFS	☐ **30 to <40 kg:** Inject 300mg SC every other week (Q2W)	QS	
		☐ **40 kg or more:** Inject 300mg SC every week (QW)	QS	
☐ **Entyvio**	☐ 300mg Vial	☐ **Starting Dose:** Infuse 300mg IV at week 0 and week 2	QS	None
	☐ 108mg Pen	☐ **Maintenance Dose:** Infuse 300mg IV every 8 weeks starting at week 6	QS	
		☐ **Maintenance Dose:** Inject 108mg SC every 2 weeks starting at week 6	QS	
☐ **Omvoh**	☐ 300mg/15mL Vial	☐ **Induction:** Infuse ☐ 300mg ☐ 900mg IV at week 0, 4 and 8	QS	None
	☐ 200mg ☐ Pen ☐ PFS	☐ **Maintenance (UC):** Inject 200mg SC every 4 weeks starting at week 12	QS	
	☐ 300mg (200+100) ☐ Pen ☐ PFS	☐ **Maintenance (CD):** Inject 300mg SC every 4 weeks starting at week 12	QS	
☐ **Rinvoq**	☐ 15mg ER Tablets	☐ **Induction Dose:** Take 45mg PO daily for ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks	QS	
	☐ 30mg ER Tablets	☐ **Maintenance Dose:** Take 15mg PO once daily	QS	
	☐ 45mg ER Tablets	☐ **Maintenance Dose:** Take 30mg PO once daily	QS	
☐ **Simponi**	☐ 100mg/mL SmartJect Autoinjector	☐ **Starting Dose:** Inject 200mg SC at week 0	QS	None
	☐ 100mg/mL Prefilled Syringe	☐ **Maintenance Dose:** Inject 100mg SC every 4 weeks starting at week 2	QS	
☐ **Skyrizi**	☐ 600mg/10mL Vial	☐ **Induction (CD):** Infuse 600mg IV at week 0, 4 and 8	QS	None
	☐ 180mg/1.2mL Prefilled Cartridge	☐ **Induction (UC):** Infuse 1200mg IV at week 0, 4 and 8	QS	None
	☐ 360mg/2.4mL Prefilled Cartridge	☐ **Maintenance Dose:** Inject 180mg SC every 8 weeks starting at week 12	QS	
		☐ **Maintenance Dose:** Inject 360mg SC every 8 weeks starting at week 12	QS	
☐ **Tremfya**	☐ 200mg Vial	☐ **Induction:** Inject 400mg (2 x 200mg) SC at week 0, 4 and 8	QS	None
	☐ 100mg ☐ Pen ☐ PFS	☐ **Induction:** Infuse 200mg IV at week 0, 4 and 8	QS	None
	☐ 200mg ☐ Pen ☐ PFS	☐ **Maintenance:** Inject 100mg SC every 8 weeks starting at week 16	QS	
		☐ **Maintenance:** Inject 200mg SC every 4 weeks starting at week 12	QS	
☐ **Ustekinumab***	☐ 130mg/26mL Vial	☐ **Starting Dose:** Infuse 260mg (2 vials) IV once at week 0 (up to 55 kg)	QS	None
	☐ 90mg/mL Prefilled Syringe	☐ **Starting Dose:** Infuse 390mg (3 vials) IV once at week 0 (>55 kg to 85 kg)	QS	None
	☐ DAW1 Product:	☐ **Starting Dose:** Infuse 520mg (4 vials) IV once at week 0 (>85 kg)	QS	None
		☐ **Maintenance Dose:** Inject 90mg SC every 8 weeks starting at week 8	QS	
☐ **Xeljanz** ☐ **Xeljanz XR**	☐ 5mg Tablets	☐ **Induction Dose:** Take 10mg PO twice daily for ☐ 8 weeks or ____ weeks	QS	
	☐ 10mg Tablets	☐ **Maintenance Dose:** Take ☐ 5mg ☐ 10mg PO twice daily	QS	
	☐ 11mg XR Tablets	☐ **Induction Dose:** Take 22mg PO once daily for ☐ 8 weeks or ____ weeks	QS	
	☐ 22mg XR Tablets	☐ **Maintenance Dose:** Take ☐ 11mg XR ☐ 22mg XR PO once daily	QS	
☐ **Other**		Directions:		

***Pharmacy may select a biosimilar based on payor guidelines unless DAW1 is selected.**

By signing, I authorize Reliant Healthcare and its employees to act as my prior authorization designated agent with medical and prescription insurers and patient assistance programs, and to substitute an approved biosimilar if required or allowed by insurance coverage. I certify that the person named is my patient, the information provided is complete and accurate to the best of my knowledge, and the therapy is medically necessary.

Physician Name (Print) | Physician Signature | Date