



Need By Date: _____ Ship To: Patient Office Other _____ Fax Copy: Rx Card Front/Back Clinical Notes Medical Card Front/Back

Patient Information		Prescriber Information	
Patient Name _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		Prescriber Name _____	
Address _____		Address _____	
City State Zip _____		City State Zip _____	
Main Phone _____	Alternate Phone _____	Phone _____	Fax _____
Social Security # _____	Date of Birth _____	Contact Person _____	
Parent/Guardian Name _____		DEA # _____	NPI # _____ License # _____

Clinical Information	
Diagnosis: <input type="checkbox"/> K50.90 Pediatric Crohn's Disease <input type="checkbox"/> K51.90 Pediatric Ulcerative Colitis <input type="checkbox"/> K20.0 Eosinophilic Esophagitis <input type="checkbox"/> Other: _____ Dx Code: _____	
Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____ Length of Treatment: _____ Reason for Discontinuing: _____	
Drug Allergies _____	Latex Allergy: <input type="checkbox"/> No <input type="checkbox"/> Yes
Weight <input type="checkbox"/> kg <input type="checkbox"/> lbs	TB Test: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ Results: _____ (please send lab results)

Prescription Information			Qty	Refills
<input type="checkbox"/> Dupixent® <small>*12+ years old, ≥40kg</small>	300mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS w/Shield	Inject 300mg subcutaneously every week	4 Syringes	_____
<input type="checkbox"/> Humira® Citrate Free Crohn's	17kg to <40kg <input type="checkbox"/> Pediatric Crohn's Disease Starter Package (2 count) 80mg/0.8mL, 40mg/0.4mL in a single-use PFS <input type="checkbox"/> 20mg PFS	Load: Inject 80mg subcutaneously on day 1, then inject 40mg two weeks later on day 15, then inject 20mg every other week starting on day 29 Maintenance: Inject 20mg subcutaneously every other week	Loading Dose 4 Week Supply	None _____
	≥40kg <input type="checkbox"/> Pediatric Crohn's Disease Starter Package (3 count) 80mg/0.8mL in a single-use PFS 40mg <input type="checkbox"/> PFS <input type="checkbox"/> Pen	Load: Inject 160mg subcutaneously as <input type="checkbox"/> two-80mg injections on day 1 or <input type="checkbox"/> 80mg on day 1 and then day 2, then inject 80mg two weeks later on day 15, then inject 40mg every other week starting on day 29 Maintenance: Inject 40mg subcutaneously every other week	Loading Dose 4 Week Supply	None _____
<input type="checkbox"/> Humira® Citrate Free UC	20kg to <40kg <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 20mg PFS <input type="checkbox"/> 40mg Pen	Load: Inject 80mg subcutaneously on day 1, then inject 40mg on day 8 and day 15, then inject maintenance dose starting on day 29 Maintenance: Inject 20mg subcutaneously every week Maintenance: Inject 40mg subcutaneously every other week	Loading Dose (4 pens) 4 Week Supply 4 Week Supply	None _____ _____
	≥40kg <input type="checkbox"/> Pediatric UC Disease Starter Package (4 count) 80mg/0.8mL in a single-use pen <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 80mg Pen	Load: Inject 160mg subcutaneously as <input type="checkbox"/> two-80mg injections on day 1 or <input type="checkbox"/> 80mg on day 1 and then day 2, then inject 80mg on day 8 and day 15, then inject maintenance dose starting on day 29 Maintenance: Inject 40mg subcutaneously every week Inject 80mg subcutaneously every other week	Loading Dose 4 Week Supply 4 Week Supply	None _____ _____
<input type="checkbox"/> Remicade®	100mg Vial	<input type="checkbox"/> Load: Infuse _____ mg (5mg/kg) at 0, 2, and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> Maintenance: Infuse _____ mg (5mg/kg) every 8 weeks	Loading Dose 8 Week Supply	None _____
<input type="checkbox"/> Other				

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By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW) By signing this form and utilizing our services, I am also authorizing ContinuumHealth to serve as my prior authorization agent with medical and pharmacy insurance providers.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date