SimfaRose
Pharmaceutical Specialties
Your Symphony Of Healthcare • Transition Care Specialist

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Crohn's Disease/Ulcerative Colitis Order Form

Today's Date: _____ Date Medication Needed: _____

First Delivery to: □ Home OR □ MD Office
Subsequent Delivery to: □ Home OR □ MD Office

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Diagnosis/ICD-9 Code:_____ Height / Weight / Allergies: _____

Insurance: _____ Policy #: _____

*** * *Please include copy of insurance card * * ***

Prior History: (Please fax clinicals)		**Prior Biologic Use:** (Please fax clinicals)		
☐ 5-ASA Prior Biologic Use	☐ Corticosteroids	☐ Remicade	☐ Humira	☐ Cimzia
☐ Immunosuppressants (6-MP or other)	☐ Surgery	☐ Rituxan®	☐ Orencia®	☐ Actemra
☐ Other: _____	☐ Methotrexate	☐ Simponi™	☐ Enbrel®	

☐ **Cimzia®** 200MG ☐ Pre-filled Syringe ☐ Lyophilized Powder
☐ Starting Therapy: ☐ SIG: 400mg SQ at wk 0, wk 2, wk 4 No Refills
☐ Maintenance: ☐ SIG: 400mg SQ q 4 wks Refills: _____ ☐ SIG: 200mg SQ q 2 wks Refills: _____

☐ **Humira®** 40mg/0.8ml
☐ Starting Therapy: ☐ Four 40 mg SQ inj. Day 1, Two 40 mg SQ inj. Day 15, #6 pens No Refills
☐ Two 40 mg SQ inj. Day 1, Two 40 mg SQ inj. Day 2, Two 40 mg SC inj. Day 15, #6 pens No Refills
☐ Maintenance: ☐ 40 mg SQ inj. every other week Refills: _____

☐ **Enbrel®** ☐ 25mg Pre-filled Syringe ☐ 25mg Multi-UseVial ☐ 50mg Pre-filled Syringe ☐ 50mg SureClick
☐ Once per week ☐ Twice per week Refills: _____

☐ **Orencia®**
☐ IV ☐ 500mg (<60kg) ☐ 750mg (60-100kg) ☐ 1000mg (>100kg) Days 1,15,29 then every 4 weeks thereafter Refills:_____
☐ Pre-filled Syringe ☐ 125mg subcutaneously once per week Refills: _____

☐ **Remicade®**
☐ Starting Therapy: ☐ 5mg/kg _____mg IV at week: 0,2,6 ☐ (_____)mg/kg _____mg IV at week: 0,2,6 ☐ Other_____
☐ Maintenance: ☐ (_____mg/kg) _____mg IV every _____weeks Refills: _____
PRN Medications: ☐ Epinephrine 0.3mg IM ☐ Diphenhydramine 25-50mg IM ☐Other: _____

☐ **Rituxan®** ☐ 100mg/10ml Vial ☐ 500mg/50ml Vial
Infuse 2 doses of 1000mg in 1 liter of 0.9% NCl every 2 weeks Refills: _____
Pre-Med: ☐ Solu-Medrol 100mg IV **PRN Meds:** ☐ Epinephrine 0.3mg IM ☐ Diphenhydramine 25-50mg IM ☐ Other: _____

MD Signature:_____Date:_____

MD Name (Printed):_____NPI:_____DEA:_____

Phone:_____Fax:_____Contact:_____

Address:_____City:_____ State:_____ Zip:_____