LeMed
SPECIALTY PHARMACY

CROHN'S DISEASE

2417 3rd Ave, Ste 406
Bronx, NY 10451
Phone: 347-913-4656
Fax: 718-231-2727

Patient Information - Please send demographic sheet and a copy of the patient's insurance cards				
Patient Name:	Date of Birth:	☐ Male ☐ Female		
Address:	City:	State:	Zip:	
Mobile Phone:	Home Phone:	Language:		
Allergies **(Required):** ☐ NKDA	Height:	Weight:	SSN:	
Medication Delivery Options: ☐ Patient's Home ☐ Hospital/Clinic Office ☐ Bedside **Delivery Address:**				

Prescriber Information			
Practice Name:	Office Contact:		
Prescriber:	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information - Please send all available chart notes including lab results	
ICD-10:	**Previous history of heart failure:** ☐ **Yes** ☐ **No**
Therapies tried and failed with length of treatments:	

***All vials requiring reconstitution will only be dispensed to prescriber's office or infusion center for reconstitution and administration**

Medication	Strength	Dose/Frequency
☐ Cimzia	200 mg/mL Pre-filled Syringe	☐ **Loading dose:** Inject 400 mg SC initially, at week 2, and at week 4 ☐ **Maintenance dose:** Inject 400 mg SC every 4 weeks
☐ Humira	**SELECT PRODUCT(s):** **Loading dose:** ☐ 80 mg/0.8 mL (3 Pen Crohn's Disease and Ulcerative Colitis Starter Kit) **Maintenance dose:** ☐ 40 mg/0.4 mL Pen (2 Pen Carton) ☐ 40 mg/0.4 mL Syringe (2 PFS Carton)	**Loading dose:** ☐ Inject 2 Pens (160 mg) SC on day 1, then inject 1 Pen (80 mg) SC on day 15 ☐ Inject 1 Pen (80 mg) SC QD on day 1 and day 2, then inject 1 Pen (80 mg) SC on day 15 **Maintenance dose:** ☐ Inject 40 mg SC every other week starting day 29 ☐ Inject 40 mg SC weekly
☐ Infliximab	**SELECT PRODUCT(s):** ☐ Remicade: 100 mg vial for reconstitution* ☐ Renfelxis: 100 mg vial for reconstitution* ☐ Inflectra: 100 mg vial for reconstitution*	☐ **Initial dose:** Infuse 5 mg/kg IV at weeks 0, 2, and 6 **Maintenance dose:** ☐ Infuse 5 mg/kg IV every 8 weeks ☐ Infuse 10 mg/kg IV every 8 weeks
☐ Stelara	**SELECT PRODUCT(s):** ☐ 130 mg/26 mL vial for infusion* ☐ 45 mg/0.5 mL PFS ☐ 90 mg/mL PFS	**Initial adult dose:** ☐ **Patients weighing up to 55 kg:** Infuse 260 mg IV once ☐ **Patients weighing 55 kg - 85 kg:** Infuse 390 mg IV once ☐ **Patients weighing over 85 kg:** Infuse 520 mg IV once ☐ **Maintenance dose:** **Inject** 90 mg SC 8 weeks after initial dose, and every 8 weeks thereafter

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize LeMed Specialty Pharmacy and/or its affiliate pharmacies to facilitate benefits investigations, complete and submit prior authorization (PA) requests, appeals, step edits and other processes necessary to obtain coverage for prescribed medications, to sign any necessary forms on my behalf of my patients, and to attach its Enrollment Form to the PA request as my signature.

***Fax does not constitute a valid prescription as per NYS Board of Pharmacy. Please electronically prescribe order.**

Prescriber Signature: _____ **Date:** _____