LINCOLN PHARMACY

831 STERLING PARKWAY, SUITE #120, LINCOLN, CA 95648

PHONE: 916-209-3618 | FAX: 916-209-3634 | www.yourlincolnpharmacy.com

Date: _____ **GASTROENTEROLOGY/CROHN'S/ULCERATIVE COLITIS PRESCRIPTION FORM**

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female
Address: _____ Date of Birth: _____
City, State,Zip: _____ SSN: _____
Phone: _____

Need by Date: _____

Ship to: ☐ Patient Home
☐ Other: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Contact Person: _____

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: ☐ 555.9 Crohn's Disease ☐ 556.9 Ulcerative Colitis ☐ 009.2 Traveler Diarrhea ☐ 572.2 Hepatic Encephalopathy ☐ _____
Date of Diagnosis/ Years with disease: _____ Try and Fail medications: _____ ALT: _____ HCV RNA: _____
Weight: _____lbs / kg Height: _____ Allergies: _____ AST: _____ TB Test: _____

PRESCRIPTION INFORMATION

☐**INITIAL PRESCRITION** ☐**PREVIOUSLY DISPENSED** **MEDICATIONS**

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
☐ Cimzia®	☐Starter Package (200mg) ☐200mg	☐ Initial Dose: Inject 400mg SQ at week 0,2,4 ☐Maintenance Dose: Inject 400 SQ every 4 weeks		
☐ Humira®	☐ 40mg/0.4ml PFS (2 doses)	☐ Initial Dose: Inject 160mg SQ on day 1, then 80mg on day 15 ☐ Maintenance: Inject 40mg SQ every other week		
☐ Remicade®	☐ 100mg/20ml vial	☐ Initial: Inject 5mg/kg IV at week 0,2,and 6 ☐ Maintenance: Inject 5mg/kg IV every 8 weeks thereafter		
☐ Simponi®	☐ 100 mg Smartject ☐ 100mg PFS	☐ Initial: Inject 200mg SQ at week 0, then 100mg at week 2 ☐ Maintenance: Inject 100mg SQ every 4 weeks, starting week 6 ☐ Other:		
☐ Xifaxan®	☐ 200mg ☐ 550mg	☐ Take _____ tablets _____ times per day		

☐ Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to **Lincoln Pharmacy** to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ **Date:** _____ ☐**Do not substitute**

Patient Support Programs:

By signing below, I authorize **Lincoln Pharmacy** to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ **Date:** _____