TruCare PHARMACY

Phone: (844) 446-0808 | Fax: (844) 446-0809

CROHN'S / GI / UC PRESCRIPTION FORM

Ship To: ☐ Patient ☐ Physician

Patient Name (Required): DOB (Required):	Physician Name: Specialty:
Home Phone: Cell Phone:	LIC#: DEA #: NPI#:
Address:	Practice Name/Hospital:
Emergency Contact Name/Phone #:	Address:
Patient SS#: Allergies: ☐ NKA	City: State: Zip:
Height: Sex: ☐M ☐F Weight: ☐ lbs. ☐ Kg	Physician's Phone: Physician's Fax:

INSURANCE INFORMATION | Please Complete or Attach Copies (front and back) of cards

Primary: ______________________ ID#: ______________________ GRP#: ______________________ PCN: ____________

DIAGNOSIS INFORMATION | Please FAX clinical notes, Labs, Tests,with the prescription to expedite the Prior Authorization

Diagnosis/Clinical Information: ______________________ ICD 10: ______________________

PRESCRIPTION INFORMATION

MEDICATION	DOS/STRENGTH	SIG	QTY	REFILLS
☐ **CIMZIA®**	☐ Prefilled Syringes (2x200mg) ☐ Lyophilized vials (2x200mg)	**Induction Dose:** Inject 400mg SC at weeks 0,2, and 4 **Maintenance Dose:** 400mg SC every 4 weeks	________	________
☐ **HUMIRA®** **Injection training from My Humira (patient must sign below)**	☐ 20mg Pen ☐ 20mg Prefilled Syringe ☐ 40mg Pen ☐ 40mg Prefilled Syringe ☐ Starter Pack	**Induction Dose:** Inject 160mg SC (four 40mg Pens) for first Dose (Day 1). Then Inject 80mg SC (two 40mg Pen) two weeks after first does (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29). **Maintenance Dose:** Inject 40mg SC (one 40mg Pen) every other week	________ ________	________
☐ **XIFAXAN®**	☐ 200mg tabs ☐ 550mg tabs	Take tablets times per day		
☐ **REMICADE®**	100mg vial			
☐ **SIMPONI®**	☐ 100mg Smartjet® ☐ 100mg Pre-filed Syringe	**Induction Dose:** Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6. **Maintenance Dose:** 100mg SC every 4 weeks starting at week 6, after induction dose.	3 1	________ ________
☐ **ENTYVIO®**	300mg vial			
☐ **AMITIZA®**	☐ 8mcg tabs ☐ 24mcg tabs	Take tablets times per day		
☐ **DELZICOL®**	400mg tabs			
☐ **DIFICID®**	200mg tabs	Take 1 tablet twice daily with or without food for 10 days	20 Tablets	
☐ **LIALDA®**	1.2mg tabs	Take tablets times per day		
☐ **LINZESS®**	☐ 72mcg tabs ☐ 145mcg tabs ☐ 290mcg tabs	Take tablets times per day		
☐ **OTHER**				

☐ DAW (Dispense as Written) **# of Medications Prescribed:** __________

Patient Signature: ______________________________ **Date:** ______________

Physician's Signature: ______________________________ **Date:** ______________

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practioner. Prescribers are reminded patients may choose any pharmacy of their choice. Pursuant to OH/MO/VT law, only 1 medication is permitted per order form. Please use new form for additional items. tcv110116