curexa® Pharmacy

Gastroenterology

toll free phone. 855.927.0390
toll free fax. 855.927.0392

Patient Information – *Please attach a copy of the patient's insurance card*

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:
Product Shipping Options: ☐ Patient's Home ☐ Prescriber Office ☐ Alternative 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*

Diagnosis/ICD-10:	Prior Failed Medications:
Is Hepatitis B ruled out? ☐ Yes ☐ No If no, has treatment started? ☐Yes ☐ No	TB/PPD test given/intended to be given before start? ☐ Yes ☐ No If yes, please attach all available lab results:

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Cimzia®	☐ Prefilled syringe starter kit	Induction dose: 400 mg Sub-Q at weeks 0, 2, and 4	☐ 1 starter kit (6 prefilled syringes)	0
	☐ 200 mg/mL prefilled syringe	Maintenance dose: ☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 1 unit (2 prefilled syringes)	
☐ Donnatal®	☐ 16.2 mg/5 mL Elixir	☐ Take _____ mL by mouth _____ daily (elixir)	☐ 118 mL ☐ 473 mL	
	☐ 16.2 mg tablets	☐ Take _____ tablets by mouth ____ times daily	☐ 90 tabs ☐ 240 tabs ☐ ___ tabs	
☐ Humira®	☐ 40 mg pens ☐ 40 mg prefilled syringe	Induction dose: ☐ Adults and children ≥ 88 lbs.: 160 mg Sub-Q day 1, 80 mg day 15, 40 mg day 29 and every other week thereafter	☐ 1 starter kit (6 pens) ☐ 3 units (6 prefilled syringes)	0
	☐ 40 mg pens ☐ 40 mg prefilled syringe	Maintenance dose: ☐ Adults and children ≥ 88 lbs.: 40 mg Sub-Q every other week	☐ 1 unit (2 pens) ☐ 1 unit (2 prefilled syringes)	
☐ Simponi®	☐ 100 mg/mL SmartJect® ☐ 100 mg/mL prefilled syringe	Induction dose: ☐ 200 mg Sub-Q at week 0, 100 mg at week 2 and every 4 weeks thereafter	☐ 3 SmartJect® autoinjectors ☐ 3 prefilled syringes	0
		Maintenance dose: ☐ 100 mg Sub-Q every 4 weeks	☐ 1 SmartJect® autoinjector ☐ 1 prefilled syringe	
☐ Stelara®	☐ 90 mg prefilled syringe	Induction dose date: _____________	1 prefilled syringe	
		Maintenance dose: ☐ Inject 1 syringe Sub-Q every 8 weeks after induction		
☐ Xifaxan®	☐ 550 mg tablets	☐ Take one tablet by mouth twice daily with or without food *(Hepatic Encephalopathy)* ☐ Take one tablet by mouth three times daily for 14 days *(IBS-D)*	☐ 42 tabs ☐ 60 tabs	
☐ Uceris®	☐ 9mg tablets ☐ 2mg/dose foam	☐ Take one tablet by mouth once daily in the morning with or without food	☐ 30 tablets ☐ 60 tablets	
		☐ Insert and administer 1 metered dose twice daily for two weeks followed by 1 metered dose once daily (foam)	☐ 2 week supply ☐ 6 week supply	
☐ Other:				

Other Medications

Medication	Dose	Directions	Quantity	Refills
☐ Amitiza®	☐ 24 mcg capsules ☐ 8 mcg capsules	☐ Take one 24 mcg capsule twice daily *(CIC & OIC)* ☐ Take one 8 mcg capsule twice daily *(IBS-C)*	60 capsules	
☐ Linzess®	☐ 72 mcg capsules ☐ 145 mcg capsules ☐ 290 mcg capsules	☐ Take one capsules by mouth daily	30 tablets	
☐ Movantik®	☐ 25 mg tablets	☐ Take 1 tablet by mouth daily in the morning	90 tablets	
☐ Relistor®	☐ 150 mg tablets	☐ Take 3 tablets by mouth daily	90 tablets	
☐ Trulance®	☐ 3 mg tablets	☐ Take one tablet by mouth daily	30 tablets	
☐ _____				

Prescriber Signature and Date (Please sign and date below)

_____ _____

Dispense as Written Date Substitution Permissible Date

☐ Check here to authorize Curexa® and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"