paramount specialty pharmacy

Crohn's / GI / Ulcerative Colitis Enrollment

P: 855.821.6300 • F: 866.266.6319
paramountsprx.com

To E-Prescribe: NABP: 3324427

Patient Information

Date Medication Needed: _____ /_____ /_____ Deliver to: ◯ Patient's Home ◯ Prescriber's Office

Patient's Name: _____ DOB: _____ /_____ /_____ Height: _____ Weight: _____

Gender: _____ SSN: _____ - _____ - _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Allergies: _____

Insurance Information

Primary Insurer: _____ Phone: _____ Person Code: _____

Policy #: _____ Group #: _____ Rx BIN: _____ Rx PCN: _____

Secondary Insurer: _____ Phone: _____ Person Code: _____

Policy #: _____ Group #: _____ Rx BIN: _____ Rx PCN: _____

Prescriber Information

Prescriber's Name: _____ Practice: _____

Address: _____ City: _____ State: _____ ZIP: _____

Contact Name: _____ Phone: _____ Fax: _____

DEA: _____ NPI: _____

Clinical Information

Diagnosis: _____ ICD-10 Code: _____

Prescription Information

Medication	Dose/Strength	Signature	Qty	Refills
◯ **Cimzia**®	◯ 2 x 200mg Prefilled Syringe ◯ 2 x 200mg Lyophilized Vitals	◯ **Induction Dose:** Inject 400mg SC at weeks 0, 2, and 4 ◯ **Maintenance Dose**: 400mg SC every 4 weeks		
◯ **Humira**® ◯ Injection Training from My Humira	◯ 20mg Pen ◯ 20mg Prefilled Syringe ◯ 40mg Pen ◯ 40mg Prefilled Syringe ◯ Starter Pack	◯ **Induction Dose:** Day 1: Inject 160mg SC (four 40mg Pens) for first dose Day 15: inject 80mg SC (two 40mg Pens) two weeks later ◯ **Maintenance Dose:** Inject 40mg SC (one 40mg Pen) every other week		
◯ **Remicade**®	◯ 100mg Vial			
◯ **Simponi**®	◯ 100mg Smartject® ◯ 100mg Prefilled Syringe	◯ **Induction Dose:** Inject 200mg SC at week 0, then 100mg SC at week 2 ◯ **Maintenance Dose:** 100mg SC every 4 weeks starting at week 6	(3) (1)	
◯ **Xifaxan**®	◯ 200mg tablets ◯ 550mg tablets	◯ Take _____ tablets _____ times daily		
◯ Other:				
◯ Other:				

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assistance program.

Patient's Signature: _____ Date: _____/_____/_____

◯ **I certify that I am prescribing the drug(s) listed above. I authorize Pharmacy to perform the above services on behalf of Physician for the benefit of the patient.**

Prescriber's Signature: _____ Date: _____/_____/_____