

Gastroenterology Enrollment Form

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Specialty pharmacy en	rollment form Rease detact	h before submitting to a	pharmacy - tear here. This form is not a ve	alid prescription in Arizona a	nd Virginia			
Patient inform	nation	Pre	escriber information					
Patient name Address Address 2 City, State, Zip Home phone DOB Last	Alternate phone Sender Cee English Spanish Other	DEA NPI Grou Add City, Phoi	criber's name up/Hospital ress State, ZIP ne Fax tact person Phone t fax a copy of patient's insurance card including l					
Medical inforn	nation (Section must be comp	leted to proces	ss prescription) (Attach separate sheet	if needed)				
Diagnosis – Please i	nclude diagnosis name with ICD-10 cod	le Add	itional information Therapy: 🗌 New 🗀	Reauthorization Rest	art			
 K50.00 Crohn's disease of small intestine without complications K50.10 Crohn's disease of large intestine without complications K50.90 Crohn's disease, unspecified, without complications Other diagnosis: ICD-10 Code Description Has a TB test been performed?		cations Aller ons Lab Prio Inje	Weightkg/lbs Heightcm/in Allergies Lab data Prior therapies Injection training required:					
Prescription in	formation							
Medication ☐ Abrilada™	Strength 20 mg/0.4 mL prefilled syringe	Adult:	Dose & Directions	Qty	Refills			
(adalimumab-afzb) ☐ Amjevita™ (adalimumab-atto)	40 mg/0.8 mL prefilled syringe 40 mg/0.8 mL pen 20 mg/0.4 mL Prefilled syringe (citrate-free) 40 mg/0.8 mL Prefilled syringe (citrate-free) 40 mg/0.8 mL Prefilled Syringe (citrate-free)	Ini	tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 intenance: Inject 40 mg SQ every other week (starting I tric Crohn's disease (≥ 6 years and adolescents): to <40 kg tiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks intenance: Inject 20 mg SQ every other week (starting I g tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 intenance: Inject 40 mg SQ every other week (starting I controlled to the starting I g tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 intenance: Inject 40 mg SQ every other week (starting I controlled to the starting I controlled to the starting I g tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 intenance: Inject 40 mg SQ every other week (starting I controlled to the starting I g tiation: Inject 160 mg SQ every other week (starting I controlled to the starting I g	Day 29) later) Day 29) 5 (two weeks later) Day 29) 5 (two weeks later)				
	autoinjector (citrate-free)	17 kg ☐ Ini ☐ Ma ≥40 kg ☐ Ini	tric (≥ 6 years and adolescents): to <40 kg tiation: Inject 80 mg SQ on Day 1, 40 mg on Day 15 (two or sintenance: Inject 20 mg SQ every other week (starting E g tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 intenance: Inject 40 mg SQ every other week (starting E	Day 29) 5 (two weeks later)				
Avsola° (infliximab-axxq)	100 mg vial		tiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 iintenance - Infuse 5 mg/kg every 8 weeks					
Cimzia* (certolizumab pegol)	☐ 200 mg/mL Vial kit ☐ 200 mg/mL Starter ☐ 200 mg/mL Prefilled syringe		tiation - Inject 400 mg SQ at Weeks 0, 2, and 4 iintenance - Inject 400 mg SQ every 4 weeks					
*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. Ship to: Patient Office-first fill only Office-all fills Other Date: Needs by date: Prescriber's Signature Date Date Date Date Date Date Date								
	Electronic or digital signatures not accepted. Electronic or digital signatures not accepted. Supervising/Collaborative Physician Information (per state requirements)							
Juper visitig/ Collabol	active in hybridian in the inflation (per state requirement							

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Patient inform	ation	Pre	scriber information				
Patient name Address Address 2 City, State, Zip Home phone DOB Last	Alternate phone Four of SS# Gender CE: □ English □ Spanish □ Other	DEA NPI Grou Addi City, Phor	criber's name up/Hospital ess State, ZIP ne Fax tact person Phone t fax a copy of patient's insurance card including both sides)				
Medical inform	nation (Section must be completed to p	roces	s prescription) (Attach separate sheet if needed)				
Diagnosis – Please in	nclude diagnosis name with ICD-10 code	Addi	itional information Therapy: \square New \square Reauthorization	☐ Resta	rt		
 ☐ K50.10 Crohn's dis ☐ K50.90 Crohn's dis ☐ Other diagnosis: I Has a TB test been p Does the patient have	isease of small intestine without complications sease of large intestine without complications isease, unspecified, without complications ICD-10 Code Description performed?	Aller Lab Prior	ghtkg/lbs Height gies data therapies ction training required:		_cm/in		
Prescription in	formation						
Medication Cyltezo* (adalimumab-adbm)	Strength Starter Kits: 40mg/0.8ml Pen Start Pack Crohn's Disease/ Ulcerative Colitis (6 pens) Maintenance: 40 mg/0.8mL Pen 40mg/0.8mL prefilled syringe	☐ Ma Pediat 17 kg t ☐ Init ☐ Ma ≥40 kg	tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) intenance: Inject 40 mg SQ every other week (Starting on Day 29) tric Crohn's disease (26 years and adolescents): to <40 kg tiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) intenance: Inject 20 mg SQ every other week (starting on Day 29)	Qty	Refills		
☐ Dupixent [®] (dupilumab)	☐ 300 mg/2ml Prefilled Pen ☐ 300 mg/2ml Prefilled Syringe	Inje	ect 300 mg SQ every week ner:				
Entyvio° (vendolizumab)	☐ 300 mg vial		tiation - Infuse 300 mg IV over 30 minutes at Weeks 0, 2, and 6 intenance - Infuse 300 mg IV over 30 minutes every 8 weeks				
Entyvio° (vendolizumab)	☐ 108 mg/0.68mL prefilled syringe☐ 108 mg/0.68mL prefilled pen	Ma	tes of initial infusions: intenance - Inject 108 mg SQ every 2 weeks				
∐ Hadlima™ (adalimumab-bwwd)		Adult: Init Ma Pediat 17 kg t Init Ma 240 kg	tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) intenance: Inject 40 mg SQ every other week (Starting on Day 29) cric Crohn's disease (26 years and adolescents): to <40 kg tiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) intenance: Inject 20 mg SQ every other week (starting on Day 29)				
*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. Ship to: Patient Office-first fill only Office-all fills Other Needs by date:							
	Dispense as Written		Substitution Permitted				
Prescriber's SignatureDate Electronic or digital signatures not accepted.			Prescriber's SignatureDate Electronic or digital signatures not accepted.				
Supervising/Collabora	ative Physician Information (per state requirements)						

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Patient inform	nation	Prescribe	er information					
Patient name Address Address 2 City, State, Zip Home phone DOB Last	Alternate phone Four of SS# Gender CE: □ English □ Spanish □ Other	DEA	oital Fax Fax Fax	i				
Medical inform	nation (Section must be completed to p	rocess preso	cription) (Attach separate s	heet if needed)				
	nclude diagnosis name with ICD-10 code		nformation Therapy: \square Ne		ı □ Resta	art		
 □ K50.10 Crohn's die □ K50.90 Crohn's die □ Other diagnosis: I Has a TB test been p □ Does the patient has	isease of small intestine without complications sease of large intestine without complications isease, unspecified, without complications ICD-10 Code Description performed? Yes No we an active infection? Yes No Review date	Allergies Lab data Prior therapi	kg/lbs Height_ es iining required: ☐ Yes ☐ No			_cm/in		
Prescription in	nformation							
Medication Hulio* (adalimumab-fkjp)	Strength 20 mg/0.4mL prefilled syringe 40 mg/0.8mL prefilled syringe 40 mg/0.8mL pen	Maintenance: Pediatric Crohn's 17 kg to <40 kg ☐ Initiation: 80 r ☐ Maintenance: ≥40 kg ☐ Initiation: Inje ☐ Maintenance:	Dose & Directions ect 160 mg SQ on Day 1, then 80 mg or Inject 40 mg SQ every other week (St disease (≥6 years and adolescents): mg SQ on Day 1, 40 mg on Day 15 (two Inject 20 mg SQ every other week (sta ct 160 mg SQ on Day 1, then 80 mg on Inject 40 mg SQ every other week (Sta	weeks later) arting on Day 29) arting on Day 29) Day 15 (two weeks later) arting on Day 29)	Qty	Refills		
∏ Humira" (adalimumab)	Starter kits: Starter kits: 80 mg/0.8mL Starter pack pre-filled pen (citrate free) Maintenance: 40 mg/0.4mL Pre-filled pen (citrate free) 40 mg/0.4mL Pre-filled syringe (citrate free) 40 mg/0.8mL Pre-filled pen kit 40 mg/0.8mL Pre-filled syringe kit Other:	Adult:	ect 160 mg SQ on Day 1, then 80 mg or Inject 40 mg SQ every other week (stars and adolescents): ect 80 mg SQ on Day 1, 40 mg on Day 1 Inject 20 mg SQ every other week (started 160 mg SQ on Day 1, then 80 mg or Inject 40 mg SQ every other week (started 160 mg SQ every other week (star	a Day 15 (two weeks later) arting Day 29) 5 (two weeks later) arting Day 29) Day 15 (two weeks later)				
*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. Ship to: Patient Office-first fill only Office-all fills Other Date: Needs by date:								

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Patient inform	nation	Pre	escriber information		
Patient name	Alternate phone t Four of SS# Gender ce: Denglish Denglish Other	DEA NPI Grou Addi City, Phoi Con	criber's name		
Medical inforn	nation (Section must be completed to p	roces	s prescription) (Attach separate sheet if needed)		
	include diagnosis name with ICD-10 code		itional information Therapy: 🗌 New 🔲 Reauthorization	☐ Resta	art
	isease of small intestine without complications isease of large intestine without complications isease, unspecified, without complications ICD-10 Code Description performed? Yes No we an active infection? Yes No Review date	Aller Lab Prio	ghtkg/lbs Height rgies data r therapies ction training required:		_cm/in
Prescription in	nformation				
Medication Hyrimoz* (adalimumab-adaz) Idacio* (adalimumab-aacf) Inflectra (infliximab-dyyb) Omvoh	Strength Starter Kit: B0 mg/0.8ml Sensoready Pen Crohn's Disease/Ulcerative Colitis starter pack B0 mg/0.8mL prefilled syringe Pediatric Crohn's starter pack B0 mg/0.8mL + 40 mg/0.4mL prefilled syringe pediatric Crohn's starter pack Maintenance: D0 mg/0.1mL prefilled syringe D0 mg/0.2mL prefilled syringe D0 mg/0.4mL prefilled syringe D0 mg/0.4mL prefilled syringe D0 mg/0.4mL prefilled syringe D0 mg/0.8mL prefilled syringe D0 mg/0.8mL auto-injector Starter Kit: D0 mg/0.8ml Crohn's disease/ulcerative colitis Start Kit Maintenance: D0 mg/0.8ml auto-injector D100 mg/0.8ml prefilled syringe	Ma Pediat 17 kg	tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) intenance: Inject 40 mg SQ every other week (Starting on Day 29) tric Crohn's disease (≥6 years and adolescents): to <40 kg tiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) intenance: Inject 20 mg SQ every other week (starting on Day 29) g tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) intenance: Inject 40 mg SQ every other week (Starting on Day 29) intenance: Inject 40 mg SQ every other week (Starting on Day 29) tric Crohn's disease (≥6 years and adolescents): g tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) intenance: Inject 40 mg SQ every other week (Starting on Day 29) tric Crohn's disease (≥6 years and adolescents): g tiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) intenance: Inject 40 mg SQ every other week (Starting on Day 29) tiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 tintenance - Infuse 5 mg/kg every 8 weeks	Qty	Refills
(mirikizumab-mrkz)	100 mg/1mL prefilled pen Date of initial infusion:	☐ Ma	ek 0, week 4, and week 8 sintenance Dosing: Inject 200mg (2 injections) subcutaneously at week 12 d every 4 weeks		
Remicade° (infliximab)	□100 mg vial		tiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 sintenance - Infuse 5 mg/kg every 8 weeks		
coverage and initiate t necessity, on my behal that support the prior information and any re Ship to:	the insurance prior authorization process for our shared pa If as my authorized agent, including any required prior aut authorization. In the event that this pharmacy determines	atient, ai horizatio s that it i	y authorized agent, where permitted by law and benefit plan spons nd to sign any necessary forms, including but not limited to, attesta on forms and the receipt and submission of patient lab values and d is unable to fulfill this prescription, I further authorize this pharmac armacy of the patient's choice or in the patient's insurer's provider in the patient of t	tions of mother patie y to forwan network.	edical ent data
			,		
Prescriber's Signature Electronic or digital signature Supervising/Collabor	Dispense as Written Date es not accepted. rative Physician Information (per state requirements)		Prescriber's Signature Electronic or digital signatures not accepted.	ate	

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Patient inforn	nation	Pre	escriber information				
Patient name Address Address 2 City, State, Zip Home phone DOB Las	Alternate phone St Four of SS# Gender English	DEA NPI Grou Addi City, Phoi Con	scriber's name A				
Medical inform	mation (Section must be completed to p		ss prescription) (Attach separate sheet if needed)				
	include diagnosis name with ICD-10 code	1	ditional information Therapy: ☐ New ☐ Reauthorization	☐ Resta	art		
	disease of small intestine without complications disease of large intestine without complications disease, unspecified, without complications ICD-10 Code Description performed?	Aller Lab Prio	ghtkg/lbs Height rgies data or therapies ection training required:		_cm/in		
Prescription in	nformation						
Medication Renflexis* (infliximab-abda)	Strength 100 mg vial		Dose & Directions itiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 aintenance - Infuse 5 mg/kg every 8 weeks	Qty	Refills		
Rinvoq* (upadacitinib)	☐ 45 mg tablet-Loading dose ☐ 15 mg tablet-Maintenance dose ☐ 30 mg tablet-Maintenance dose	Ulc Ma	rohn's disease induction: Take 45 mg PO once daily for 12 weeks cerative colitis induction: Take 45 mg PO once daily for 8 weeks aintenance dose: Take 15 mg PO once daily ternative maintenance dose: Take 30 mg PO once daily				
∏ Simlandi* (adalimumab-ryvk)	□ 40 mg/0.4 mL auto-injector	☐ Ma Pediat ≥40 k ç ☐ Ini	uitiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) aintenance: Inject 40 mg SQ every other week (Starting on Day 29) atric Crohn's disease (26 years and adolescents):				
Simponi° (golimumab)	☐ 100 mg/mL SmartJect autoinjector ☐ 100 mg/mL Prefilled syringe	I	itiation - Inject 200 mg SQ at Week 0 then 100 mg at Week 2 aintenance - Inject 100 mg SQ every 4 weeks				
∏ Skyrizi" (Risankizumab-rzaa)	☐ 600 mg/10 mL single-dose vial-initiation dose ☐ 360 mg/2.4 mL single-dose prefilled cartridge with On- body injector-maintenance dose ☐ 180 mg/1.2 mL single-dose prefilled cartridge with On-body injector-maintenance dose Date of initial infusion:	as o	itiation-Infuse 600 mg as initial IV dose at Week 0, Week 4, and Week 8 directed by prescriber tenance dose: 50 mg by SQ injection at week 12, and every 8 weeks thereafter 10 mg by SQ injection at week 12, and every 8 weeks thereafter				
☐ Stelara* (ustekinumab)	☐ 130 mg/26 mL solution single dose vial ☐ 90 mg/mL Prefilled syringe Date of initial infusion:	as Ma	itiation - Infuse:				
Uelsipity (etrasimod)	□2 mg tablet	☐ Tal	ske 1 tablet by mouth once daily				
*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. Ship to: Patient Office-first fill only Office-all fills Other Date: Needs by date:							
Patient Office	,		·				
Prescriber's Signature Electronic or digital signatur Supervising/Collabo	Dispense as Written Date res not accepted. prative Physician Information (per state requirements)		Substitution Permitted Prescriber's Signature Dat Electronic or digital signatures not accepted.	e			

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Patient inform	nation	Pre	escriber information	า			
Patient name Address Address 2 City, State, Zip Home phone DOB Last	Alternate phone Four of SS# Gender CE: □ English □ Spanish □ Other	DEA NPI Grou Addi City, Phoi Con	scriber's name up/Hospital ress s, State, ZIP ne tact person st fax a copy of patient's insurance	Fax Phone _			
Medical inform	nation (Section must be completed to p	roces	ss prescription) (Attach	separate sheet	if needed)		
	nclude diagnosis name with ICD-10 code		litional information Thera			☐ Resta	irt
K50.10 Crohn's die K50.90 Crohn's di Other diagnosis: I Has a TB test been p Does the patient hav	isease of small intestine without complications sease of large intestine without complications isease, unspecified, without complications ICD-10 Code Description berformed?	Aller Lab Prio	ghtkg/lbs rgies data r therapies cction training required: □				_cm/in
Prescription in	formation						
Medication Xeljanz* (tofacitinib)	Strength 5 mg tablet 10 mg tablet 11 mg XR tablet 22 mg XR tablet	□Ma	Dose & Dir tiation: ☐ 10 mg twice daily for 8 we ☐ XR: 22 mg once daily for 8 wee sintenance: ☐ 5 mg twice daily ☐ XR: 11 mg or ☐ 10 mg twice daily ☐ XF	eks eks nce daily R: 22 mg once daily		Qty	Refills
∐Yusimry™ (adalimumab-aqvh)	☐ 40 mg/0.4mL prefilled syringe ☐ 40 mg/0.4mL auto-injector	☐ Ma Pediat ≥40 kç ☐ nit	: itiation: Inject 160 mg SQ on Day 1, tl aintenance: Inject 40 mg SQ every of tric Crohn's disease (±6 years and ad g tiation: Inject 160 mg SQ on Day 1, th aintenance: Inject 40 mg SQ every of	hen 80 mg on Day 1 ther week (Starting lolescents): en 80 mg on Day 15 ther week (Starting	5 (two weeks later) on Day 29) 6 (two weeks later) on Day 29)		
∐Yusimry™ (adalimumab-aqvh)	□ 40 mg/0.8mL prefilled syringe □ 40 mg/0.8mL auto-injector	☐ Ma Pediat ≥40 k ç ☐ nit	itiation: Inject 160 mg SQ on Day 1, tl aintenance: Inject 40 mg SQ every of tric Crohn's disease (≥6 years and ad	hen 80 mg on Day 1 ther week (Starting lolescents): en 80 mg on Day 15	5 (two weeks later) on Day 29) 6 (two weeks later)		
Zeposia* (ozanimod)	0.92 mg capsule 7-Day starter pack 37 Day starter kit (starter pack + 0.92 mg capsules)		tiation: Take 0.23 mg once daily for o for days 5-7, then take 0.92 m thereafter aintenance: Take 0.92 mg once daily				
Zymfentra™ (infliximab-dyyb)	☐ 120 mg/mL auto-injector ☐ 120 mg/mL prefilled syringe	comp	to initiation, an IV induction regime olleted prior to starting subcutaneous aintenance: Inject 120mg subcutane	s therapy.			
coverage and initiate the necessity, on my behalf that support the prior a information and any reschipto:	tion: I authorize this pharmacy and its representatives to a the insurance prior authorization process for our shared part fas my authorized agent, including any required prior authorization. In the event that this pharmacy determines lated materials related to coverage of the product to ano	atient, ai horizations that it i	nd to sign any necessary forms on forms and the receipt and so is unable to fulfill this prescript armacy of the patient's choice o	, including but no ubmission of pat ion, I further autl or in the patient's	ot limited to, attestat ient lab values and o horize this pharmacy s insurer's provider n	ions of me ther patie to forwar etwork.	edical nt data
Patient Office-	first fill only Office-all fills Other		T	Date:	Needs by date	;	
Prescriber's Signature Electronic or digital signatures Supervising/Collabor	Dispense as Written Date s not accepted. ative Physician Information (per state requirements)		Prescriber's Signature Electronic or digital signatures not accep	Substitution Po	ermitted Da		

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