PEDIATRIC GASTROENTEROLOGY

New Orleans, LA **toll free** 888.355.4191 **toll free fax** 888.355.4192
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

DATE: _____ NEEDS BY DATE: _____ **SHIP TO:** ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFORMATION

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFORMATION

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑ Pediatric Crohn's Disease: K50.90 ❑ Pediatric Ulcerative Colitis: K51.90 ❑ Other: Dx code _____ Condition _____
Drug Allergies: _____ Weight: _____ ❑ kg ❑ lb
Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____
_____ Length of Treatment: _____ Reason for Discontinuing: _____
_____ Length of Treatment: _____ Reason for Discontinuing: _____
Does patient have a latex allergy? ❑ No ❑ Yes **TB Test:** ❑ No ❑ Yes Date: _____ Results: _____ (Please send lab results)

	PRESCRIPTION INFORMATION		QUANTITY	REFILLS
❑ Humira® Citrate Free	**17kg to < 40kg** ❑ Pediatric Crohn's Disease Starter Package (2 count) 80mg/0.8mL, 40mg/0.4mL in a single-use PFS	Load: Inject 80mg subcutaneously on day 1, then inject 40mg two weeks later on day 15, then inject 20mg every other week	Loading Dose	None
	❑ 20mg PFS	Maintenance: Inject 20mg subcutaneously every other week	4 Week Supply	_____
	≥ 40kg ❑ Pediatric Crohn's Disease Starter Package (3 count) 80mg/0.8mL in a single-use PFS	Load: Inject 160mg subcutaneously as ❑ two-80mg injections on day 1 **or** ❑ 80mg on day 1 and then day 2, then inject 80mg two weeks later on day 15, then inject 40mg every other week	Loading Dose	None
	40mg ❑ PFS ❑ Pen	Maintenance: Inject 40mg subcutaneously every other week	4 Week Supply	_____
❑ Remicade®	100mg Vial	❑ Load: Infuse _____ mg (5mg/kg) at 0, 2, and 6 weeks, then every 8 weeks thereafter ❑ Maintenance: Infuse _____ mg (5mg/kg) every 8 weeks	Loading Dose 8 Week Supply	None _____
❑ Other				

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date