

Date: _____ Auth #: _____ Auth Dates: _____ UPMC prior auth form attached

Patient Information

First Name: _____ Last Name: _____ DOB: _____ SSN: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alternate Phone: _____ Caregiver/ Emergency Contact: _____ Phone: _____
 Weight: _____ Allergies: _____ Latex Allergy: Yes No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
 Insured: _____ Insured: _____
 Phone: _____ Phone: _____
 Policy #: _____ Group #: _____ Policy #: _____ Group #: _____

ICD 10

<p>Crohns Disease</p> <input type="checkbox"/> K50.00 Regional enteritis, small intestine <input type="checkbox"/> K50.80 Regional enteritis, small & large intestine <input type="checkbox"/> K50.10 Regional enteritis, large intestine <input type="checkbox"/> K50.90 Regional enteritis, unspecified site <p>Fistula (Secondary to Crohns disease)</p> <input type="checkbox"/> K60.3 Anal fistula <input type="checkbox"/> K63.2 Fistula of intestine, excluding rectum and anus	<p>Ulcerative Colitis</p> <input type="checkbox"/> K51.80 Ulcerative (chronic) enterocolitis <input type="checkbox"/> K51.20 Ulcerative (chronic) proctitis <input type="checkbox"/> K51.50 Left-sided ulcerative (chronic) colitis <input type="checkbox"/> K51.80 Other ulcerative colitis <input type="checkbox"/> Other: <input type="checkbox"/> K51.80 Ulcerative (chronic) ileocolitis <input type="checkbox"/> K51.30 Ulcerative (chronic) proctosigmoiditis <input type="checkbox"/> K51.00 Universal ulcerative (chronic) colitis <input type="checkbox"/> K51.90 Ulcerative colitis, unspecified
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Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg tablets <input type="checkbox"/> 10mg tablets <input type="checkbox"/> 11mg XR tablets <input type="checkbox"/> 22mg XR tablets	Immediate release: <input type="checkbox"/> Initial Dose: 10mg orally twice daily (maximum of _____ week/s) <input type="checkbox"/> Maintenance Dose: 5mg orally twice daily	60	
		Extended release: <input type="checkbox"/> Initial Dose: 22mg orally once daily (maximum of _____ week/s) <input type="checkbox"/> Maintenance Dose: 11mg orally once daily	30	
<input type="checkbox"/> Xifaxan®	<input type="checkbox"/> 550mg tablets	Directions: _____	60	
<input type="checkbox"/> Zeposia®	<input type="checkbox"/> 7 Day Starter <input type="checkbox"/> 0.92mg capsule	<input type="checkbox"/> Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule for 3 days <input type="checkbox"/> Take one capsule by mouth daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 0.92mg/30 capsules	

Prescriber Information

Date Shipment Needed: _____ Ship to: Patient Physician/ Clinic Other: _____
 Physician's Name: _____ Office Contact Name: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Physician's Signature: _____ Date: _____