aetna®

Crohn's/Ulcerative Colitis Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809

Customer Service: 1-866-782-ASRX (1-866-782-2779) **Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)**

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: _____
Member ID#: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: *(Check one)*: ☐M.D. ☐D.O. ☐N.P. ☐P.A.		
Address:	City:	State:	ZIP:
Phone: Fax:	DEA #: NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ CIMZIA **Initial dose:** ☐ CIMZIA PFS STARTER KIT ☐ CIMZIA 200mg VIALS ☐ CIMZIA **Maintenance dose:** ☐ CIMZIA 200mg PFS ☐ CIMZIA 200mg VIALS	**Initial dose:** ☐ 400mg SQ at week 0, week 2, and week 4 **Maintenance dose:** ☐ 400mg SQ every 4 weeks ☐ Other: _____	☐ Initial doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other: _____	_____
☐ ENTYVIO 300mg VIALS. ☐ SWFI ☐ 250ml NS IV Bag ☐ NS Flush	**Initial dose:** ☐ 300mg IV at week 0, week 2, and week 6 **Maintenance dose:** ☐ 300mg IV every 8 weeks ☐ Other: _____	☐ Initial doses ***then:*** ☐ 1 dose ☐ Other: _____	_____
☐ HUMIRA **Initial dose:** ☐ HUMIRA PEN CROHN'S STARTER KIT ☐ HUMIRA 40mg/0.4ml PFS ☐ HUMIRA 40mg/0.8ml PFS ☐ Other: _____ ☐ HUMIRA **Maintenance dose:** ☐ HUMIRA 40mg/0.4ml ☐PEN ☐ PFS ☐ HUMIRA 40mg/0.8ml ☐PEN ☐ PFS ☐ HUMIRA 20mg/0.2ml PFS ☐ HUMIRA 20mg/0.4ml PFS ☐ HUMIRA 10mg/0.1ml PFS ☐ HUMIRA 10mg/0.2ml PFS ☐ Other: _____	**Initial dose:** ☐ 160mg SQ on day 1, then 80mg on day 15 ☐ 80mg SQ on day 1 and 2, then 80mg on day 15 ☐ Other: _____ **Maintenance dose:** ☐ 40mg SQ every other week ☐ 40mg SQ every week ☐ Other: _____	☐ Initial doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other: _____	_____
☐ INFLECTRA 100mg VIALS ☐ SWFI ☐ 250ml NS IV Bag ☐ NS Flush	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) **Initial dose:** ☐ Infuse IV at week 0, week 2, and week 6 **Maintenance dose:** ☐ Infuse IV every _____ weeks ☐ Other: _____	☐ Initial doses ***then:*** ☐ 1 dose ☐ Other: _____	_____

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.

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First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: _____
Member ID#: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: *(Check one)*: ☐M.D. ☐D.O. ☐ N.P. ☐P.A.		
Address:	City:	State:	ZIP:
Phone: / Fax:	DEA #: / NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ REMICADE 100mg VIALS ☐ SWFI ☐ 250ml NS IV Bag ☐ NS Flush	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) **Initial dose:** ☐ Infuse IV at week 0, week 2, and week 6 **Maintenance dose:** ☐ Infuse IV every _____ weeks ☐ Other: _____	☐ Initial doses ***then:*** ☐ 1 dose ☐ Other: _____	_____
☐ SIMPONI ☐ SIMPONI 100mg PFS ☐ SIMPONI 100mg PEN	**Initial dose:** ☐ 200mg SQ at week 0, then 100mg SQ at week 2 **Maintenance dose:** ☐ 100mg SQ every 4 weeks ☐ Other: _____	☐ Initial doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other: _____	_____
☐ STELARA **Initial dose:** ☐ STELARA 130mg VIAL ☐ STELARA **Maintenance dose:** ☐ STELARA 45mg PFS ☐ STELARA 45mg VIAL ☐ STELARA 90mg PFS	***DOSE:*** _____mg (Wt: _____kg ***OR*** _____lbs) **Initial dose:** ☐ Infuse IV as a single dose **Maintenance dose:** ☐ Inject 90mg SQ every 8 weeks ☐ Other: _____	☐ Initial dose ***then:*** ☐ 1 dose ☐ Other: _____	_____
☐ TYSABRI	☐ Infuse 300mg IV every 4 weeks. ☐ Other: _____ Available under a restricted distribution program called CD-TOUCH. Please contact the TOUCH Prescribing Program at 1-800-456-2255.	☐ 1 month	_____
☐ Other: _____			_____

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

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