RARE SPECIALTY PHARMACY
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398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____
Date Needed: _____

Patient Name: _____ Date of Birth: ____/____/____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____

(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)

Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____

IDC-10 Diagnosis Code: ❑K50.00 Crohn's Disease ❑B18.2 Chronic Hep C ❑K58.0 IBS-D ❑K51.0 Ulcerative Colitis ❑K58.0 IBS-D ❑Other: _____
Patient currently on therapy? ❑Yes ❑No Type/Medication(s): _____
PPD (TB Test) ❑Yes ❑No Date_____ Will patient stop taking the medication(s) before starting the new medication? ❑Yes ❑No
If yes, how long should patient wait before starting the new medication? _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____
Previously treated for this condition? ❑Yes ❑No Medication(s) failed _____

GASTROENTEROLOGY ORDER FORM

❑**HUMIRA Citrate-Free PEN Starter Kit** QTY: 1 Kit Refills: 0
❑SIG: Inject 160mg SQ on Day 1, then inject 80mg SQ on Day 15
HUMIRA Maintenance Therapy
❑HUMIRA Citrate-Free PEN 40 mg/0.4 mL ❑HUMIRA Citrate-Free PFS 40 mg/0.4 mL
❑Maintenance: Inject 40mg SQ every other week starting on Day 29 QTY: 2 Refills: ____
❑Alt. Dosage: _____ QTY: ____ Refills: ____

❑**SIMPONI** ❑SMARTJECT Autoinjector 50mg/0.5mL ❑PFS 50mg/0.5mL
❑SMARTJECT Autoinjector 100mg/1mLw
❑Starter:200mg SQ at week 0, then 100mg SQ at week 2 QTY: ___ Refills:0
❑Maintenance: 100mg SQ every 4 weeks QTY: 1 Refills: ____
❑Other: _____ QTY: ___ Refills: ____

❑**STELARA** Patient Weight (kg): _____
❑130 mg/26 mL vial ❑45mg SD Vial ❑45mg PFS ❑90mg PFS
❑Starter: Infuse _____ mg IV initially at week 0. QTY: ___ vials Refills: 0
❑Maintenance: Inject 90mg SQ 8 weeks after the initial IV dose, then every 8 weeks. QTY: ___ Refills:____

Weight of Patient (Kg)	Recommended Dosage	Vials
≤ 55 kg or less	260 mg	2
55 kg to 85 kg	390 mg	3
≥ 85 kg	520 mg	4

❑**XELJANZ** ❑5mg tablet ❑10mg tablet
SIG: Take 1 tablet by mouth twice daily QTY: 60 Refills: ____
❑**XELJANZ XR** ❑11mg tablet ❑22mg tablet
SIG: Take 1 tablet by mouth daily QTY: 30 Refills: ____

❑**CIMZIA** ❑PFS 2-ct Pack ❑PFS 6-ct Starter Kit Refills: _____
❑Starter: Inject 400mg SQ on day 1, at week 2 & at week 4 QTY: 1 Kit
❑Maintenance: Inject 400mg SQ every 4 weeks QTY: 1 Pack

❑**DIFICID** ❑200mg tablet QTY: 20 Refills: _____
SIG: Take one tablet orally twice daily for 10 days with or without food

❑**ENTYVIO** ❑300mg vial
❑Starter: Infuse 300mg IV at wks 0, 2, & 6, then maint. QTY: 3 Refills: _____
❑Maintenance: Infuse 300mg IV every 8 weeks QTY: 1 Refills: _____

❑**RELISTOR** ❑8mg PFS ❑12mg PFS ❑150mg tablet
SIG:_____ QTY:_____ Refills:_____

❑**DONNATAL** 16.2mg tablet
SIG:_____ QTY:_____ Refills:_____
❑**ZOFRAN** ❑4mg ❑8mg
SIG:_____ QTY:_____ Refills:_____

❑**XIFAXAN** ❑200mg ❑550mg
❑1 200mg TAB PO TID x 3 Days QTY: 9 Refills: ____
❑1 550mg TAB PO BID QTY: 60 Refills: ____
❑1 550mg TAB PO TID x 14 Days QTY: 42 Refills: ____
SIG: _____ QTY: _____ Refills: ____

HEPATITIS B ORAL THERAPIES ❑BARACLUDE ❑0.5mg ❑1.0mg
❑EPIVIR HBV 100mg ❑HEPSERA® 10mg ❑VEMLIDY 25mg ❑VIREAD 300mg
SIG: _____ QTY:_____ Refills: _____

❑ **REZDIFFRA** ❑60mg ❑80mg ❑100mg
❑ SIG: <100 kg (actual body weight): 80mg once daily QTY: ___ Refills: _____
❑ SIG: ≥100 kg (actual body weight): 100mg once daily QTY: ___ Refills: _____

OTHER:_____ SIG:_____ QTY:____ Refills:_____

❑**SUTAB** QTY: 24 Refills: 0
❑**MOVIPREP** QTY: 1 Refills: 0
❑**PLENVU** QTY: 3 Refills: 0
SIG: Use as directed on colonoscopy instructions

❑**EPCLUSA** ❑400mg/100mg tablet (brand)
❑**SOFOSBUVIR/VELPATASVIR** ❑400mg tablet (generic) ❑100mg tablet (generic)
SIG: Take 1 tablet by mouth daily QTY: 28 Refills: _____

❑**HARVONI** ❑90mg/400mg tablet (brand)
❑**LEDIPASVIR/SOFOSBUVIR** ❑90mg/400mg tablet (generic)
SIG: Take 1 tablet by mouth daily QTY: 28 Refills: _____

❑**MAVYRET** ❑100mg glecaprevir/40mg pibrentasvir tablet
SIG: Take 3 tablets orally once daily with food for 8 weeks QTY: 84 Refills: _____

❑**VOSEVI** ❑400mg sofosbuvir/ 100mg velpatasvir/ 100mg voxilaprevir tablet
SIG: Take 1 tablet by mouth daily with food for 12 weeks QTY: 28 Refills: 2

❑**ZEPATIER** ❑Grazoprevir 100mg/ elbasvir 50mg tablet
SIG: Take 1 tablet by mouth daily QTY: 28 Refills: _____

❑**RIBAVIRIN** ❑200mg capsules ❑200mg tablets
❑SIG:<75kg: 400mg in the AM and 600mg in the PM QTY: ____ Refills: _____
❑SIG:>75kg: 600mg in the AM and 600mg in the PM QTY: ____ Refills: _____
❑SIG:Other: _____ QTY: ____ Refills: _____

❑**RINVOQ** ER tablet ❑15mg ❑30mg ❑45mg
❑SIG:Starter: 45mg PO QD for 8 weeks QTY: ____ Refills: _____
❑SIG:Maintenance: 15 mg PO QD QTY: ____ Refills: _____
❑SIG:Other: _____ QTY: ____ Refills: _____

❑**SKYRIZI** ❑600mg SDV
SIG: Starter: Infuse 600mg Intravenously at weeks 0, 4, and 8. QTY: ____ vials
❑**SKYRIZI** ❑180mg On-Body Injector Kit ❑360mg On-Body Injector Kit
Maintenance: Administer on-body injector prefilled cartridge on thigh or abdomen at week 12 and every 8 weeks thereafter QTY: ____ kit Refills: _____

❑**REMICADE** ❑**AVSOLA** ❑**INFLECTRA** ❑**RENFLEXIS** ❑100mg SDV
Crohn's Disease ❑Starter: Infuse 5 mg/kg at 0, 2, and 6 weeks QTY: ____vials
❑Maintenance: Infuse 5 mg/kg every 8 weeks thereafter. Refills: _____
Ulcerative Colitis ❑Starter: Infuse 5 mg/kg at 0, 2, and 6 weeks QTY: ____vials
❑Maintenance: Infuse 5 mg/kg every 8 weeks thereafter. Refills: _____

❑**ZEPOSIA** *Ulcerative Colitis*
❑Starter: 7-day starter pack (0.23mg, 0.46mg) QTY: 7 capsules Refills:0
SIG: Take by mouth as directed on package.
❑Maintenance: 0.92mg QTY: 30 capsules Refills: _____
SIG: Take 1 capsule (0.92mg) by mouth once daily starting on Day 8.

❑**TREMFYA** ❑100mg/mL PFS ❑100mg/mL Pens ❑200mg/2mL Pens ❑200mg/2mL PFS ❑200mg/20mL Vial
❑Starter: Infuse 200mg IV on weeks 0, 4, and 8 **OR** Inject 400mg SUBQ on weeks 0, 4, and 8 QTY: ____ Refills: ____
❑Maintenance: 100mg SQ every 4 weeks beginning at week 16 **OR** 200mg SQ every 4 weeks beginning at week 12 QTY: ____ Refills: ____
❑If applicable, enroll patient in *Tremfya WithMe*

❑**REBYOTA** ❑150mL kit QTY: 1 kit Refills: 0
SIG: 150 mL (contents of 1 bag) as a single dose rectally, administered 24 to 72 hours after completion of C. difficile treatment regimen

❑**VOQUEZNA** ❑10mg tablet ❑20mg tablet
SIG: Take 1 tablet by mouth daily QTY: _____ Refills: _____

This prescription will be filled generically unless the prescriber writes "DAW" here: _____

Prescriber Name/Practice:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____
License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____
Prescriber's Signature (signature required, no stamps): _____ Date: _____