Patient Information ***Date:*** ____/____/____

Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____ E-Mail: _____

Biologics & Other GI Associated Medications

Medication	Strength	Directions	Quantity	Refills
☐ **Apriso ER**	375mg	Take _____ Capsules by mouth _____times daily		
☐ **Asacol HD**	800mg	take 2 tablets by motuh 3 times daily for 6 weeks		
Cimzia ☐ Starter Kit ☐ Vial ☐ Prefilled Syringe		400mg initially and at Weeks **2** and **4**. If Response occurs, follow with 400mg every 4 weeks		
☐ **Dificid**	200mg	take 1 tablet by mouth every 12 hours for 10 days		
☐ **Humira Starter Kit (6 Pens)**	40mg/0.8mL	Inject 160mg (4 pens) for the initial Dose **THEN** 2 weeks later (on day 15) inject 80mg (2 pens)		
☐ **Humira Maintenance (2 Pens)**	40mg/0.8mL	Inject 40mg (1 pen) every other week		
☐ **Linzess**	145mcg ☐ 290mcg ☐	Take _____ Capsules by mouth once daily		
Simponi ☐ Auto Injector Pen ☐ Prefilled Syringe	100mg/1mL	200 mg injected subcutaneously at week 0 **THEN** 100mg at week 2 THEN 100mg every 4 weeks for maintenance		
☐ **Stelara PFS Maintenance**	90mg	Inject 90mg dose 8 weeks after initial IV dose, then every 8 weeks thereafter		
☐ **Viberzi**	75mg ☐ 100mg ☐	Take 1 tablet by mouth twice daily		
☐ **Xifaxan**	200mg ☐ 550mg ☐	Take _____ Tablets by mouth _____times daily		

OTC Items (circle):

Critic-Aid | Balneol | Calmol 4 Suppositories | Calmoseptine | HC 1% Suppositories | Miralax | Recticare

Additional Notes:

_____

Prescriber Signature:

_____ _____

Dispense As Written Substitution Permissible