SYNERGEN Rx
www.synergenrx.com

Inflammatory Bowel Disease

Phone 404-585-7517
Fax: 404-900-9209
NPI: 1811550528

Patient Information (Please attach insurance card)

Name:	☐ M ☐ F	DOB: ___/___/___	
Street:	City	State:	Zip:
Phone:	Alt Phone:	Allergies:	

Clinical Information (Please attach all pertinent clinicals and lab results)

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other _____

Weight: _____ TB Test ☐ Y ☐ N Result: _____

Previous Tried/Failed Medications: Duration:

_____ _____

_____ _____

Active Infections ☐ Y ☐ N

Hep B Negative ☐ Y ☐ N

Prescription

Injection Training ☐ Prescribers Office ☐ Specialty Pharmacy

Drug Therapy	*Dosing*	*Directions*	*Quantity*	*Refills*
☐ Humira Citrate Free ☐ Pen ☐ PFS	☐ Starter Kit	Inject 160 mg (Two 80mg/0.8mL doses) under the skin on day 1, then 80 mg on Day 15	3	
	☐ Maintenance	Inject 40 (One 40mg/0.4 mL dose) under the skin every 2 weeks		
☐ Cimzia	☐ Starter Kit	Inject 400 mg (Two 200mg PFS) under the skin on weeks 0, 2, & 4	6 Syringes	
	☐ Maintenance	Inject 400 mg (Two 200mg PFS) under the skin every 4 weeks		
☐ Dificid	200mg	Take 1 tablet by mouth 2 times daily		
☐ Entyvio	☐ Induction	Infuse 300 mg IV weeks 0, 2, and 6 then maintenance dose	3 Vials	
	☐ Maintenance	Infuse 300 mg IV every 8 weeks		
☐ Ibsrela	50mg	Take 1 tablet immediately before first meal and prior to dinner	60	
☐ Inflectra ☐ Renflexis (Biosimilars for Remicade)	☐ Induction	Infuse 5 mg/kg (Weight based dose per infusion: _____) IV weeks 0, 2, and 6 then maintenance dose		
	☐ Maintenance	Infuse 5 mg/kg (Weight based dose per infusion: _____) IV ever 8 weeks		
☐ Rinvoq	☐ 45mg *(Induction Only)*	Take 1 tablet by mouth daily for 8 weeks	56	
	☐ 15mg	Take 1 tablet by mouth daily	30	
	☐ 30mg *(Refractory, severe or extensive disease)*	Take 1 tablet by mouth daily	30	
☐ Simponi Autoinjector ☐ Simponi PFS	☐ Induction	Inject 200 mg (Two 100mg doses) under the skin on day 1, then 100 mg under the skin on day 15	3	
	☐ Maintenance	Inject 100 mg under the skin every 4 weeks		
☐ Stelara	☐ 130 mg vial	Induction Infusion Dose: ☐ 260 mg (Wt <55kg) ☐ 390 mg (Wt 55-85kg) ☐ 520 mg (Wt >85kg)		
	☐ 90 mg syringe	Inject 90 mg under the skin every 8 weeks		
☐ Xeljanz *Induction Dose*	☐ 10 mg	Take 1 tablet by mouth twice daily for at least 8 weeks then start maintenance	120 Tablets	
	☐ 22 mg XR	Take 1 tablet by mouth once daily for at least 8 weeks then start maintenance	60 Tablets	
	☐ 5 mg	Take 1 tablet by mouth twice daily		
	☐ 11 mg XR	Take 1 tablet by mouth once daily		
☐ Xifaxan	☐ 550 mg	☐ Take 1 tablet by mouth 3 times daily for 14 days		

Prescriber information

Deliver To: ☐ Patient ☐ Office

Prescriber:			Supervising Physician:	
Contact Name:			Preferred method of contact: ☐ Phone ☐ Fax ☐ Email	
Phone:	Ext:	Fax:	Email:	
Street:	City:		State:	Zip:
Signature:	Date:		NPI	

*By signing this form I authorize Synergen RX LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patients insurance plan and to facilititate and enroll patients into patient assistance programs with manufacturers and other foundations.