



Fax the completed form to
(818) 236-2504

Questions? Call (818) 236-2500
Monday to Friday, 10 am to 6 pm

E-prescribing? Send to Foothill Remedy Drugs
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

1 Patient

Or attach a patient face sheet

Last name _____ First name _____ Date of birth _____

Sex ☐ F ☐ M ☐ X Height _____ Weight _____ ☐ kg ☐ lb Allergies ☐ None known _____

Address _____ City _____ State _____ ZIP _____

Cell phone _____ Other phone _____ Email _____

Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other _____

2 Insurance

Or attach copies of the cards, front and back

Primary plan _____ Member ID _____ Group # _____ Phone _____

Secondary plan _____ Member ID _____ Group # _____ Phone _____

3 Prescriber

Prescriber name _____ NPI _____ License # _____

Practice _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Office contact _____

Contact phone _____ Contact email _____

4 Clinical information

Please attach recent labs and notes

Diagnosis ☐ Crohn's disease K50. _____ ☐ Ulcerative colitis K51. _____ ☐ Other _____

Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Fistulas ☐ Past bowel surgery ☐ Ostomy

IV starting doses ☐ Completed, last dose _____ ☐ Scheduled for _____ ☐ Not needed

Tried before ☐ Mesalamine ☐ Steroids ☐ Azathioprine or 6-MP ☐ Methotrexate ☐ Biologic _____

Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from _____

Reason for switching _____

TB test ☐ Negative ☐ Positive Date _____ Hepatitis B screen ☐ Negative ☐ Positive ☐ Not done

Current medications ☐ List attached _____

5 Delivery

Needed by _____ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy

Delivery is free within 25 miles of our Tujunga store.

Patient name _____ Date of birth _____

6 Prescription

Check each medication to fill. Directions and quantity can be changed.

☐ New start: also dispense the loading doses in each checked drug's label

Medication	Strength	Directions	Quantity	Refills
Injections				
☐ Humira adalimumab	40 mg/0.4 mL pen	Inject 40 mg subcut every other week	2 pens	_____
☐ Adalimumab biosimilar the plan's preferred biosimilar	40 mg pen	Inject 40 mg subcut every other week	2 pens	_____
☐ Cimzia certolizumab pegol	200 mg/mL syringe	Inject 400 mg (2 syringes) subcut every 4 weeks	2 syringes	_____
☐ Simponi golimumab (ulcerative colitis)	100 mg/mL SmartJect	Inject 100 mg subcut every 4 weeks	1 pen	_____
☐ Stelara ustekinumab, after the IV starting dose	90 mg/mL syringe	Inject 90 mg subcut every 8 weeks	1 syringe	_____
☐ Ustekinumab biosimilar the plan's preferred biosimilar	90 mg/mL syringe	Inject 90 mg subcut every 8 weeks	1 syringe	_____
☐ Skyrizi risankizumab-rzaa, after IV starting doses	180 or 360 mg on-body	Inject ____ mg subcut every 8 weeks (180 or 360 mg)	1 cartridge	_____
☐ Tremfya guselkumab	100 mg or 200 mg pen	Inject 100 mg every 8 weeks or 200 mg every 4 weeks	1 pen	_____
Tablets and capsules				
☐ Xeljanz tofacitinib (ulcerative colitis)	5 mg or 10 mg tablet	Take 1 tablet by mouth twice daily	60 tablets	_____
☐ Zeposia ozanimod, 7-day starter pack first	0.92 mg capsule	Take 1 capsule by mouth once daily	30 capsules	_____
☐ Velsipity etrasimod (ulcerative colitis)	2 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____
☐ Budesonide EC Entocort EC or generic	3 mg capsule	Take 3 capsules (9 mg) by mouth every morning	90 capsules	_____
☐ Budesonide ER Uceris or generic	9 mg tablet	Take 1 tablet by mouth every morning	30 tablets	_____
☐ Azathioprine Imuran or generic	50 mg tablet	Take ____ mg by mouth once daily	30-day supply	_____
Other medication (write in)				
☐ _____	_____	_____	_____	_____
☐ _____	_____	_____	_____	_____

7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature _____ Date _____

☐ Do not substitute Prescriber initials _____ California law requires the prescriber to initial this box to prevent substitution.