Gastroenterology Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

(*Complete the following or include demographic sheet*)

Patient Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Primary Phone: ____________ DOB: ____________

Alternate Phone: ____________

Gender: ☐ Male ☐ Female

Last 4 digits SS#: ____________

PRESCRIBER INFORMATION

Name: ______________________

State License #: ____________ NPI #: ____________

DEA #: ______________________

Group or Hospital: ______________________

Address: ______________________

City, State Zip: ______________________

Phone: ____________ Fax: ____________

Contact Person: ____________ Phone: ____________

INSURANCE INFORMATION If available, please fax copy of prescription insurance cards with this form (front and back).

MEDICAL INFORMATION

Prior Failed Medication(s):	Reason for Discontinuing	Length of Treatment
☐		____/____/_____-____/____/______
☐		____/____/_____-____/____/______
☐		____/____/_____-____/____/______

☐ K50.90 Chron's Disease
☐ K51.90 Ulcerative Colitis
☐ K580 IBS, diarrhea-predominant
☐ Other: ______________________

Patient Clinical Assessment:

Height: ________ inch/ft Weight: ________ lb/kg

Allergies: ______________________

Has TB Test been performed? ☐YES ☐NO Specific Date: ____________

Hepatitis B ruled out or being treated:
☐ Yes ☐ No

PRESCRIPTION

Drug		Directions & Quantity	Refills
Cimzia	☐ Prefilled Syringe ☐ Lyophilized Powder	☐ **INITIAL:** Inject 400mg SQ on day 1, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200mg SQ every 2 weeks (Quantity: 2)	
Humira	☐ Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160mg SQ on day 1, then 80mg on day 14 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40mg SQ every other week (Quantity: 2)	
Remicade	☐ Vials	☐ **INITIAL**: Infuse _5mg/____kg=______mg on day 0, 14, and 42 (Quantity: _____) ☐ **MAINTENANCE:** Infuse _____mg every 8 weeks (Quantity: _____)	
Simponi	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 200mg SQ on day 1, then 100mg on day 14 (Quantity: 3) ☐ **MAINTENANCE:** Inject 100mg SQ every 4 weeks (Quantity: 1)	
Entyvio	☐ 300mg in 20 mL Vial	☐ **INITIAL / MAINTENANCE** : Week zero two and six weeks, then every eight weeks thereafter	
Xifaxan	☐ 200mg ☐ 550mg	______________________ ☐ Take 1 tablet 3 times daily for 14 days	
Uceris	☐ 9mg Tab	☐ Take 1 tablet by mouth qam with or without food	
Viberzi	☐ 75mg ☐ 100mg	☐ Take orally twice daily with food ☐ Take orally twice daily with food	
Other			

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Pharmacy to coordinate injection training or infusion

PHYSICIAN SIGNATURE

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: Date: ____________

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.