Whole Health Pharmacy

Gastroenterology Enrollment Form

Fax: 949-340-8008 Phone: 949-305-0788

□ **Urgent Request**

Rep: _____

PATIENT INFORMATION

Please complete the following or ***send patient demographic sheet***

Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Mobile Phone _____
DOB _____ Last Four of SS _____ Gender _____
Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
DEA _____
NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis - Please include diagnosis name with ICD-10 code

□ K72.90 Hepatic encephalopathy
□ B18.1 Chronic Hepatitis B
□ K58.0 Irritable bowel syndrome with Diarrhea
□ K50.90 Crohn's disease, unspecified without complications
□ K51.90 Ulcerative colitis, unspecified without complications
□ K20.0 Eosinophilic esophagitis
□ Other Diagnosis: ICD-10 Code _____
Date of Diagnosis _____

Additional information | Therapy □ New □ Reauthorization □ Restart

Weight _____ kg/lbs Height _____ cm/in
Allergies _____
Lab Data _____
Prior Therapies _____
Concomitant Medications _____
Additional Comments
Injection Training Required: □ Yes □ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
□ Xifaxan	□ 200mg □ 550mg	□ Take 1 tablet PO twice daily □ Take 1 tablet PO three times daily		
□ Baraclude	□ 0.5mg	□ Take 1 tablet PO every day	□ 30 days	
□ Viread	□ 300mg	□ Take 1 tablet PO every day	□ 30 days	
□ Vemlidy	□ 25mg	□ Take 1 tablet PO every day	□ 30 days	
□ Cimzia	□ Starter Kit □ 200 mg PFS	□ Inject 400mg SQ on days 0,14, & 28 □ Inject 400mg SQ every 28 days	□ 28 days	
□ Dupixent	□ 300mg Pre-filled Pen □ 300mg Pre-filled Syringe	□ Inject 300m SQ every week	□ 28 days	
□ Entyvio	□ 300mg/20ml vial	□ Infuse 300mg IV on weeks 0,2, & 6 □ Infuse 300mg IV every 8 weeks		
□ Humira CF	□ 40mg/0.4 ml Prefilled Syringe □ 40mg/0.4 ml Pens □ 80mg/ml/0.4ml Pens □ Crohn's Starter kit	□ Inject 40mg SQ every other week □ Inject 40mg SQ once weekly □ Inject 80mg SQ every other week □ Inject 160mg SQ on day 1 then inject 80mg on day 15 then start maintenance dose (Crohn's Starter pack)	□ 28 days	
□ Inflectra	□ 100mg vial	□ Infuse 5mg/kg IV on weeks 0,2, & 6 (starter dose) □ Infuse 5mg/kg IV every 8 weeks		
□ Remicade	□ 100mg vial	□ Infuse 5mg/kg IV on weeks 0,2, & 6 (starter dose) □ Infuse 5mg/kg IV every 8 weeks		
□ Renflexis	□ 100mg vial	□ Infuse 5mg/kg IV on weeks 0,2, & 6 (starter dose) □ Infuse 5mg/kg IV every 8 weeks		
□ Simponi	□100mg/ ml Smartject Autoinjector □ 100mg/ml PFS	□ Inject 200mg SQ on week 0. Then inject 100mg SQ on weeks 2, & 6 (Starter) □ Inject 100mg SQ every 4 weeks		
□ Skyrizi	□ 600mg/10ml SDV □ 360mg/2.4ml OBI Cartridge	□ Inject 600mg IV infused over 1 hour on week 0, 4 and 8. Then inject 360mg SQ on week 12 and every 8 weeks thereafter. □ Inject 360mg SQ every 8 weeks		
□ Stelara	□ 130mg/26 ml solution Single dose vial □ 90/ml PFS	□ Initiation – Infuse: □ 260mg □ 390mg □ 520mg As initial IV dose as directed by prescriber □ Inject 90mg SQ every 8 weeks (begin dosing 8 weeks after IV induction dose) Maintenance		
□ Xeljanz	□ 5 mg tablets □ 10 mg tablets	□ Take 5 mg twice daily □ Take 10 mg twice daily	□ 30 days	
□ Xeljanz XR	□ 11 mg tablets □ 22 mg tablets	□ Take 11 mg by mouth every day □ Take 22 mg by mouth every day for 16 weeks	□ 30 days	
□ Zeposia	□ 7 day Starter Pack □ Starter Kit (1 month supply) □ 0.92 mg maintenance	□ Days 1-4 Take 023 mg once daily Days 5-7 Take 0.46 mg once daily Day 8 and thereafter Take 0.92 mg once daily □ Take 1 capsule by mouth once daily	□ 1 Starter Pack □ 30 days	
□ Other				

Ship to: □ Patient □ Office □ Other _____ Date: _____ Need by Date _____

**** Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature: _____ Date: _____