Gastroenterology Enrollment Form

Fax: 949-340-8008P
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

□ ICD-10 Code______________________________
Description______________________________
Date of Diagnosis________________
Has TB test been performed? □ Yes □ No
Does the patient have an active infection? □ Yes □ No

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
□ 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 _____mg/kg IV every ___ weeks (maintenance dose)		
□ Remicade	□ 100mg vial	□ Infuse 5mg/kg IV on weeks 0,2, & 6 (starter dose) □ Infuse _____mg/kg IV every ___ weeks (maintenance dose)		
□ Renflexis	□ 100mg vial	□ Infuse 5mg/kg IV on weeks 0,2, & 6 (starter dose) □ Infuse _____mg/kg IV every ___weeks (maintenance dose)		
□ Rinvoq	□ 15 mg tablets □ 30 mg tablets □ 45 mg tablets (starter)	□ Induction dose: Take 45 mg once daily for 8 weeks □ Take 15mg once daily □ Take 30mg once daily	□ 28 day pack □ 30 days	
□ Simponi	□100mg/ ml Smartject Autojector □ 100mg/ml PFS	□ Inject 200mg SQ on week 0. Then inject 100mg SQ on weeks 2, & 6 (Starter) □ Inject 100mg SQ every 4 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 ____ 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		
□ 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: ______________________

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