



Gastroenterology Enrollment Form

Fax: 909-284-9140
 Phone: 909-266-0016
 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
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 200 mg PFS	<input type="checkbox"/> Inject 400mg SQ on days 0,14, & 28 <input type="checkbox"/> Inject 400mg SQ every 28 days	<input type="checkbox"/> 28 days	
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 300mg Pre-filled Pen <input type="checkbox"/> 300mg Pre-filled Syringe	<input type="checkbox"/> Inject 300m SQ every week	<input type="checkbox"/> 28 days	
<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300mg/20ml vial	<input type="checkbox"/> Infuse 300mg IV on weeks 0,2, & 6 <input type="checkbox"/> Infuse 300mg IV every 8 weeks		
<input type="checkbox"/> Humira CF	<input type="checkbox"/> 40mg/0.4 ml Prefilled Syringe <input type="checkbox"/> 40mg/0.4 ml Pens <input type="checkbox"/> 80mg/ml/0.4ml Pens <input type="checkbox"/> Crohn's Starter kit	<input type="checkbox"/> Inject 40mg SQ every other week <input type="checkbox"/> Inject 40mg SQ once weekly <input type="checkbox"/> Inject 80mg SQ every other week <input type="checkbox"/> Inject 160mg SQ on day 1 then inject 80mg on day 15 then start maintenance dose (Crohn's Starter pack)	<input type="checkbox"/> 28 days	
<input type="checkbox"/> Inflectra	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Infuse 5mg/kg IV on weeks 0,2, & 6 (starter dose) <input type="checkbox"/> Infuse _____ mg/kg IV every _____ weeks (maintenance dose)		
<input type="checkbox"/> Remicade	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Infuse 5mg/kg IV on weeks 0,2, & 6 (starter dose) <input type="checkbox"/> Infuse _____ mg/kg IV every _____ weeks (maintenance dose)		
<input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Infuse 5mg/kg IV on weeks 0,2, & 6 (starter dose) <input type="checkbox"/> Infuse _____ mg/kg IV every _____ weeks (maintenance dose)		
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15 mg tablets <input type="checkbox"/> 30 mg tablets <input type="checkbox"/> 45 mg tablets (starter)	<input type="checkbox"/> Induction dose: Take 45 mg once daily for 8 weeks <input type="checkbox"/> Take 15mg once daily <input type="checkbox"/> Take 30mg once daily	<input type="checkbox"/> 28 day pack <input type="checkbox"/> 30 days	
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100mg/ml Smartject Autojector <input type="checkbox"/> 100mg/ml PFS	<input type="checkbox"/> Inject 200mg SQ on week 0. Then inject 100mg SQ on weeks 2, & 6 (Starter) <input type="checkbox"/> Inject 100mg SQ every 4 weeks		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg/26 ml solution Single dose vial <input type="checkbox"/> 90/ml PFS	<input type="checkbox"/> Initiation – Infuse: <input type="checkbox"/> 260mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg As initial IV dose as directed by prescriber <input type="checkbox"/> Inject 90mg SQ every _____ weeks (begin dosing 8 weeks after IV induction dose) Maintenance		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg tablets <input type="checkbox"/> 10 mg tablets	<input type="checkbox"/> Take 5 mg twice daily <input type="checkbox"/> Take 10 mg twice daily	<input type="checkbox"/> 30 days	
<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> 11 mg tablets <input type="checkbox"/> 22 mg tablets	<input type="checkbox"/> Take 11 mg by mouth every day <input type="checkbox"/> Take 22 mg by mouth every day for 16 weeks	<input type="checkbox"/> 30 days	
<input type="checkbox"/> Zeposia	<input type="checkbox"/> 7-day Starter Pack <input type="checkbox"/> Starter Kit (1 month supply) <input type="checkbox"/> 0.92 mg maintenance	<input type="checkbox"/> Days 1-4 Take 0.23 mg once daily. Days 5-7 Take 0.46 mg once daily. Day 8 and thereafter, take 0.92 mg once daily <input type="checkbox"/> Take 1 capsule by mouth once daily		
<input type="checkbox"/> 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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