



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

- 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
 - Other Diagnosis: 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"/> Xifaxan	<input type="checkbox"/> 200mg <input type="checkbox"/> 550mg	<input type="checkbox"/> Take 1 tablet PO twice daily <input type="checkbox"/> Take 1 tablet PO three times daily		
<input type="checkbox"/> Baraclude	<input type="checkbox"/> 0.5mg	<input type="checkbox"/> Take 1 tablet PO every day	<input type="checkbox"/> 30 days	
<input type="checkbox"/> Viread	<input type="checkbox"/> 300mg	<input type="checkbox"/> Take 1 tablet PO every day	<input type="checkbox"/> 30 days	
<input type="checkbox"/> Vemlidy	<input type="checkbox"/> 25mg	<input type="checkbox"/> Take 1 tablet PO every day	<input type="checkbox"/> 30 days	
<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"/> 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 5mg/kg IV every 8 weeks		
<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 5mg/kg IV every 8 weeks		
<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 5mg/kg IV every 8 weeks		
<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 8 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"/> 1 Starter Pack <input type="checkbox"/> 30 days	
<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 lab 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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