GASTRO HEALTH
Specialty Pharmacy

GASTROENTEROLOGY

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DATE: ____________ NEEDS BY DATE: ____________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ____________

PATIENT INFO

Patient Name

Address

City, State, Zip

Main Phone   Alternate Phone

Social Security #

Date of Birth   ❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name

DEA #   NPI #   License #

Address

City, State, Zip

Phone   Fax

Contact Person

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis Code: ❑ K50.90 Crohn's Disease ❑ K51.90 Ulcerative Colitis ❑ Other: ____________

Drug Allergies: ____________

History: • Has the Patient been treated previously for this condition? ❑ Yes ❑ No

❑ NSAIDS	Duration________	❑ Sulfasalazine	Duration________	❑ Corticosteroid	Duration________
❑ MTX	Duration________	❑ 5-ASA (5-Aminosalicylates)	Duration________	❑ 6-MP (6-Mercaptopurine)	Duration________
❑ Biologics	Duration________	❑ Azathioprine	Duration________	❑ Other	Duration________

• Is the patient currently on any therapy? ❑ Yes ❑ No List Meds: ____________

• Will patient stop taking Meds before starting the new med? ❑ Yes ❑ No • How long will the patient wait before starting the new med? ____________

• Other meds patient is on? ____________

• Has patient received PPD (skin test)? ❑ Yes ❑ No • Results: ____________

PRESCRIPTION INFORMATION

		PRESCRIPTION INFORMATION	QUANTITY	REFILLS
❑ Cimzia®	❑ 200x2 Prefilled Syringe ❑ 200x2 LYO Powder	❑ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 ❑ Inject 400mg subcutaneously once every 4 weeks	1 Kit 4 week supply	none ________
❑ Creon®	❑ 3,000 ❑ 6,000 ❑ 12,000 ❑ 24,000 ❑ 36,000	Take ___ capsules three times daily with meals and ___ capsules with ___ snacks daily for a total of ___ capsules a day	________	________
❑ Dificid®	200mg Tablet	1 tablet by mouth twice a day with or without food for 10 days.	20	________
❑ Entyvio®	300mg vial	❑ Loading Dose: Infuse 300mg IV over 30 minutes at week 0, week 2 and week 6 ❑ Maintenance: Infuse 300mg IV over 30 minutes every 8 weeks	3 ________	none ________
❑ Humira®	❑ Crohn's/UC Starter Package (6 - 40mg Pens) ❑ 40mg Pen ❑ 40mg PFS	Inject 160mg given as ❑ Four 40mg SubQ day 1 OR ❑ Two 40mg SubQ days 1 & 2 then week 2 inject 80mg (Two 40mg injections) subcutaneously on day 15 ❑ Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	none ________
❑ Humira® Citrate Free	❑ Crohn's/UC Starter Package (3 - 80mg Pens) ❑ 40mg Pen ❑ 40mg PFS	Inject 160mg given as ❑ Two 80mg SubQ Day 1 OR ❑ One 80mg SubQ days 1 & 2 then week 2 inject 80mg subcutaneously on day 15 ❑ Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	none ________
❑ Remicade® Wt: ______	100mg Vial	Loading Dose: ❑ Infuse ________mg IV on week 0, week 2, week 6, then Maintenance: ❑ Infuse ________mg IV every ______ weeks for _____ infusions	Loading dose 4 week supply	none ________
❑ Simponi® UC	❑ 100mg SmartJect ❑ 100mg Prefilled Syringe	❑ Inject 200mg subcutaneously at week 0, then 100mg at week 2, 100mg every 4 weeks ❑ Inject 100mg subcutaneously once every 4 weeks	Loading dose 4 week supply	none ________
❑ Epipen®	0.3mg	Inject 1 pen intramuscularly once, may repeat if necessary. Call 911 if needed.	2	________
❑ Stelara®	90mg Prefilled Syringe	Inject 90 mg subcutaneously every 8 weeks Infusion Dose Date: ________	8 week supply	________
❑ Xeljanz®	❑ 10mg ❑ 5mg	1 tablet by mouth twice a day	60	________
Xifaxan®	550mg Tablets	❑ 1 tablet by mouth twice a day ❑ 1 tablet by mouth three times a day	1 month supply 2 week supply	________ ________
❑ Other	________	________	________	________

By signing this form and utilizing our services, you are authorizing Gastro Health Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

____________________________   ____________

Prescriber's Signature (no stamps)   If Brand required check ❑ DAW   Date

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