Gastroenterology

Patient Information

Patient Name:	Date of Birth:	☐ Male ☐ Female	
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Social Security Number:	E-Mail:		

Allergies (Required): ☐ NKDA

Product Shipping Options ☐ Patient's Home ☐ Prescriber Office ☐ Alternative Address:

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:	Office Contact:		
Prescriber:	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Notes: Please send last 3 available chart notes and lab results with order

Clinical Information

Diagnosis/ICD-10:	Prior Failed Medications:
Is Hepatitis B ruled out? ☐ Yes ☐ No If no, has treatment started? ☐Yes ☐ No	TB/PPD test given/intended to be given before start? ☐ Yes ☐ No ****Please send documentation****

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Cimzia®	2 x 200 mg prefilled syringe	☐ Starter: Inject 400 mg Sub-Q at week 0, 2, and 4	1 starter kit	0
		☐ Maintenance: Inject 400 mg Sub-Q every 4 weeks	1 kit	
☐ Humira®	☐ Crohn's/Ulcerative Colitis Starter Kit ☐ 40 mg/0.8 mL prefilled syringe	☐ Starter: Inject 160 mg Sub-Q on day 1 and 80 mg on day 15	1 starter kit (6 pens) 6 PFS	0
	☐ 40 mg/0.8 mL pens ☐ 40 mg/0.8 mL prefilled syringe	☐ Maintenance: Inject 40 mg Sub-Q every other week starting day 29	2 pens/PFS	
☐ Humira® citrate-free	☐ Crohn's/Ulcerative Colitis Starter Kit ☐ 40 mg/0.4 mL prefilled syringe	☐ Starter: Inject 160 mg Sub-Q on day 1 and 80 mg on day 15	1 starter kit (3 pens) 6 PFS	0
	☐ 40 mg/0.4 mL pens ☐ 40 mg/0.4 mL prefilled syringe	☐ Maintenance: Inject 40 mg Sub-Q every other week starting day 29	2 pens/PFS	
☐ Simponi®	☐ 100 mg SmartJect® autoinjector ☐ 100 mg prefilled syringe	☐ Starter: Inject 200 mg Sub-Q at week 0, 100 mg at week 2	3 pens/PFS	0
		☐ Maintenance: Inject 100 mg Sub-Q every 4 weeks	1 pen/PFS	
☐ Stelara®	90 mg prefilled syringe	Induction dose date: ____\ ____\ _____	1 prefilled syringe	
		☐ Maintenance: Inject 1 syringe Sub-Q every 8 weeks after induction		
☐ Uceris®	☐ 9 mg tablet ☐ 2 mg/dose foam	☐ Take one tablet by mouth once daily in the morning with or without food for 8 weeks	☐ 4 week supply ☐ 8 week supply	
		☐ Insert and administer 1 metered dose twice daily for two weeks followed by 1 metered dose once daily for 4 weeks (foam)	☐ 2 week supply ☐ 6 week supply	
☐ Xeljanz®	☐ 5 mg tablets ☐ 10 mg tablets	Take one tablet by mouth twice daily	60 tablets	
☐ Xifaxan®	☐ 550 mg tablet	☐ Take one tablet by mouth twice daily with or without food *(Hepatic Encephalopathy)*	60 tablets	
		☐ Take one tablet by mouth three times daily for 14 days *(IBS-D)*	42 tablets	
☐ Other:				
Support Medications				
☐ Amitiza®	☐ 24 mcg capsules ☐ 8 mcg capsules	☐ Take one 24 mcg capsule twice daily with food *(CIC & OIC)* ☐ Take one 8 mcg capsule twice daily with food *(IBS-C)*	60 capsules	
☐ Linzess®	☐ 72 mcg capsules ☐ 145 mcg capsules ☐ 290 mcg capsules	Take 1 capsule by mouth daily on an empty stomach	30 capsules	
☐ Relistor®	☐ 150 mg tablets	Take 3 tablets by mouth daily on an empty stomach	90 tablets	
☐ Trulance®	☐ 3 mg tablets	Take one tablet by mouth daily	30 tablets	
☐ Viberzi™	☐ 75 mg tablets ☐ 100 mg tablets	Take one tablet by mouth twice daily with food	30 tablets	

Prescriber Signature and Date (Please sign and date below)

_____ _____

Substitution Permissible Date Dispense as Written Date

☐ Check here to authorize the receiving pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"