Gastrointestinal Enrollment Form: A-H

InfuCare Rx

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PATIENT INFORMATION				PRESCRIBER INFORMATION		
Name:	SSN#:			Prescribing Practitioner:	NPI:	
Address:				Address:		
City:	State/Zip:			City:	State/Zip:	
Telephone:	DOB:	M ☐ F ☐		Office:	DEA:	
Language Preference:	Wt:	Ht:		Contact:	Phone:	Fax:

PLEASE FAX COPY OF: ☐ **PRESCRIPTION FRONT & BACK** ☐ **CLINICAL NOTES** ☐ **MEDICAL CARD FRONT & BACK**

PRESCRIPTION

New ☐ Refill ☐ | Ship by: | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

Drug		Directions and Quantity	Refills
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Qauntity: 2)	
Entyvio™	☐ Vials	☐ **INITIAL:** Infuse 300 mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3) ☐ **MAINTENANCE:** Infuse 300 mg IV over 30 minutes every 8 weeks (Quantity: 1)	
Humira® CItrate Free	☐ Adult Crohn's/UC Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ Pediatric Crohn's Starter Kit ☐ Pre-filled Syringe 20 mg	**PEDIATRIC: ***WEIGHT REQUIRED***_____** ☐ **INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 15, then 20 mg every **other** week starting on day 29 (Quantity: 2) ☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) *****Intended for weight 17 kg/37 lbs to <40kg 88 lbs*****	
	☐ Pediatric Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg every **other** week starting on day 29 (Quantity: 2) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) *****Intended for weight ≥ 40 kg 88 lbs*****	
Humira®	☐ Adult Crohn's/UC Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ Pediatric Crohn's Starter Kit ☐ Pre-filled Syringe 20 mg	**PEDIATRIC: ***WEIGHT REQUIRED***_____** ☐ **INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 15, then 20 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) *****Intended for weight 17 kg/37 lbs to <40kg 88 lbs*****	
	☐ Pediatric Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg every **other** week starting on day 29 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) *****Intended for weight ≥ 40 kg 88 lbs*****	

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ Pentasa	☐ (_____)	☐	_____
☐ Entocort	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Allergies:

☐ K50.00 Crohn's disease of small intestine, without complications
☐ K50.10 Crohn's disease of large intestine, without complications
☐ K50.80 Crohn's disease of both intestines, without complications
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.50 Left-sided Ulcerative Colitis, without complications
☐ K51.80 Other Ulcerative Colitis, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ Other: _____

Date of Diagnosis: _____/_____/_____ Active TB is ruled out: ☐ Hep B Ruled out/treated: ☐

Date of Diagnosis: _____/_____/_____ **Date of Diagnosis:** _____/_____/_____

Additional Clinical Information:

Injection Training:

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ FOSRX/FAST to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: **Date:**

CONFIDENTIALITY NOTICE