Gastrointestinal Enrollment Form: I-Z

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

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
Remicade®	Vials	**INITIAL:** Infuse ________ mg IV on day 0, 14, and 42 (Quantity: ______) **MAINTENANCE:** Infuse ________ mg IV every 8 weeks (Quantity: _______)	
	Vials	**INITIAL:** Intravenous induction regimen of 5mg/kg given at 0, 2, and 6 weeks **MAINTENANCE:** Intravenous induction regimen of 5mg/kg every 8 weeks thereafter	
Simponi®	100 mg Smartject® Pen 100 mg Pre-filled Syringe	**INITIAL:** Inject 200 mg SQ on day 0, then 100 mg on day 14 (Quantity: 3) **MAINTENANCE:** Infject 100 mg SQ every 4 weeks (Quantity: 1)	
Stelara®	130 mg/26 mL Vials Pre-filled Syringe **Weight Required:** _______ 45 mg/0.5 mL Vials 90 mg/mL Vial	**INITIAL INTRAVENOUS DOSAGE:** A single intravenous infusion using weight based dosing: Up to 55g=260mg (2 vials), >55g to 85kg=390 mg (3 vials), >85kg=520 mg (4 vials) **MAINTENANCE:** Inject 90 mg SQ 8 weeks after intial dose, then every 8 weeks thereafter (1 syringe) **SUBCUTANEOUS DOSAGE:** **≤ 100 kg:** 45 mg subQ initially and then 4 weeks later, 45 mg subQ every 12 weeks after **>100 kg:** 90 mg subQ initially and then 4 weeks later, 90 mg subQ every 12 weeks after	
Xeljanz®	10 mg Tablets	**INITIAL:** Take 10 mg PO twice daily (Quantity: 60 with 1 refill)	
	5 mg Tablets 10 mg Tablets	**MAINTENANCE:** Take 5 mg PO twice daily (Quantity: 60) **MAINTENANCE:** Take 10 mg PO twice daily (Quantity: 60)	

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: ____

Additional Clinical Information:

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

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

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

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error please destroy this document immediately.

Revised 8/2020