

# Gastroenterology Enrollment Form

Fax Referral To: 877-277-9155  
Phone: 877-828-3940

✂ Please cut along the dotted lines before submitting to a pharmacy.

Date Required: \_\_\_\_\_ Ship To: Patient MD Office Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)**

Primary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Prescription Card: \_\_\_\_\_ ID: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_

**PATIENT DIAGNOSIS/CLINICAL INFORMATION**

K50.00 Crohn's Disease  
 K51.90 Ulcerative Colitis  
 Other: \_\_\_\_\_  
 Prior Medication Failed: \_\_\_\_\_  
 Length of Treatment: \_\_\_\_\_  
 Reason for Discontinuation: \_\_\_\_\_

TB/PPD Test: Positive Negative Date Read: \_\_\_\_\_  
 Weight: \_\_\_\_\_ kg lbs Height: \_\_\_\_\_ cm in %BSA: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ NKDA  
 Injection Training/Home Health RN visit is necessary: Yes No  
 Site of Care: Home MD Office Other: \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Medication:	Dose/Strength:	Directions:	Refills:
Cimzia®	200mg prefilled syringe 200mg vial	<b>Initial:</b> Inject 400mg (two 200mg injections) SUBQ on day 0, 14, and 28 (Quantity: 6) <b>Maintenance:</b> Inject 400mg (two 200mg injections) SUBQ every 4 weeks (Quantity: 2)	
Entyvio®	300mg vial	<b>Initial:</b> Infuse 300mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3) <b>Maintenance:</b> Infuse 300mg IV over 30 minutes every _____ weeks (Quantity: 1)	
Humira® Humira® Citrate Free	Crohn's/UC Starter Package 40mg pen 40mg prefilled syringe	<b>Initial:</b> Inject 160mg SUBQ on day 1, then 80 mg day 15, then maint. dose (1 pkg) <b>Maintenance:</b> Inject 40mg SUBQ every other week (Quantity: 2)	
Avsola®	100mg vial	<b>Initial:</b> Infuse IV _____ mg per kg (Dose _____ mg) at 0, 2, and 6 weeks (Quantity: _____) <b>Maintenance:</b> Infuse IV _____ mg per kg (Dose _____ mg) every _____ weeks (Quantity: _____) Other: _____  Pharmacist will round to the nearest 100 Give exact dose (do NOT round)	
Inflectra®			
Remicade™			
Renflexis™			
Simponi®	100mg SmartJect® Pen 100 mg prefilled syringe	<b>Initial:</b> Inject 200mg SUBQ on day 0, then 100 mg on day 14 (Quantity: 3) <b>Maintenance:</b> Inject 100mg SUBQ every 4 weeks (Quantity: 1)	
Skyrizi IV®	600mg/10mL vial  600mg/10mL vial x 2	<b>Crohn's Initial:</b> 600mg administered by IV over at least one hour at week 0, week 4, and week 8 (Quantity: 3) **Induction Dosing Only <b>Ulcerative Colitis Initial:</b> 1200mg administered by IV over at least two hours at week 0, week 4, and week 8 (Quantity: 3) **Induction Dosing Only	
Stelara®	130mg (26mL vials) 90mg (2x 45mg vials)	<b>Initial:</b> Weight based dosing, infuse IV up to 55kg = 260mg (2 vials), > 55kg to 85kg = 390mg (3 vials), > 85kg = 520mg (4 vials) <b>Maintenance:</b> Inject 90mg SUBQ 8 weeks after initial dose, then every 8 weeks thereafter	
Other:			

**Premedications & Other Medications:**

▶ Infusion supplies as per protocol  
 ▶ Anaphylaxis Kit as per protocol

Acetaminophen: \_\_\_\_\_ mg PO prior to infusion  
 Diphenhydramine: \_\_\_\_\_ mg PO IV  
 250ml 0.9% NaCl for hydration  
 Other: \_\_\_\_\_

**Flush Protocol:**  
 ▶ NaCl 0.9% 10ml  
 ▶ Before and after infusion

*By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.*

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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