

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			PRESCRIBER INFORMATION		
Patient Name: _____			Prescriber Name: _____		
Address: _____			Address: _____		
City, State, Zip: _____			City, State, Zip: _____		
Home Phone: _____			Phone: _____		
Cell Phone: _____			Fax: _____		
Date of Birth: _____ Gender: _____			DEA #: _____ NPI #: _____		
Emergency Contact: _____ Phone: _____			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: _____	
To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:					
PATIENT DIAGNOSIS/CLINICAL INFORMATION					
K50.00 Crohn's Disease		TB/PPD Test: Positive Negative		Date Read: _____	
K51.90 Ulcerative Colitis		HBV: Positive Negative NA		Date Read: _____	
Other: _____		Weight: _____ kg lbs		Height: _____ cm in %BSA: _____	
Prior Medication Failed: _____		Allergies: _____		NKDA	
Length of Treatment: _____		Injection Training/Home Health RN visit is necessary: Yes No			
Reason for Discontinuation: _____		Site of Care: Home MD Office Other: _____			
PRESCRIPTION INFORMATION					
Medication:	Dose/Strength:	Directions:			Refills:
Entyvio®	300mg vial	Initial: Infuse 300mg IV over 30 minutes at week 0, week 2, and week 6 (Quantity: 3) Maintenance: Infuse 300mg IV over 30 minutes every _____ weeks (Quantity: 1)			
Avsola®	100mg vial	Initial: Infuse IV _____ mg per kg (Dose _____ mg) at 0, 2, and 6 weeks (Quantity: _____) Maintenance: Infuse IV _____ mg per kg (Dose _____ mg) every _____ weeks (Quantity: _____) Other: _____			
Inflectra®					
Remicade™					
Renflexis™					
Pharmacist will round to the nearest 100 Give exact dose (do NOT round)					
Omvo®	300 mg/15 mL vial	Ulcerative Colitis: Infuse 300mg IV over at least 30 minutes at week 0, week 4, and week 8 (Quantity 3) ***Induction dosing only. Crohn's Disease: Infuse 900mg IV over at least 90 minutes at week 0, week 4, and week 8 (Quantity 3) ***Induction dosing only.			
Skyrizi®	600mg/10mL vial 600mg/10mL vial x 2 180mg/1.2mL On-Body Injector KIT 360mg/2.4mL On-Body Injector KIT	Crohn's Initial: 600mg administered by IV over at least one hour at week 0, week 4, and week 8 (Quantity: 3) Crohn's Maintenance: 180mg or 360mg SUBQ at week 12 and every 8 weeks thereafter. Ulcerative Colitis Initial: 1200mg administered by IV over at least two hours at week 0, week 4, and week 8 (Quantity: 3) Ulcerative Colitis Maintenance: 180mg or 360mg SUBQ at week 12 and every 8 weeks thereafter.			
Stelara®	130mg (26mL vials) 90mg (2x 45mg vials)	Initial: Weight based dosing, infuse IV up to 55kg = 260mg (2 vials), > 55kg to 85kg = 390mg (3 vials), > 85kg = 520mg (4 vials) Maintenance: Inject 90mg SUBQ 8 weeks after initial dose, then every 8 weeks thereafter			
Tremfya®	200mg/20mL vial IV Induction 200mg/2ml x 2 Pen SUBQ Induction Pack 100mg/mL SUBQ 200mg/2mL SUBQ	IV Induction: 200mg IV over at least 60 minutes at week 0, week 4, and week 8. SUBQ Induction: 400mg SUBQ (given as two consecutive injections of 200mg each) at week 0, 4, and 8. Maintenance: Inject 100mg SUBQ at week 16 and every 8 weeks thereafter. Maintenance: Inject 200mg SUBQ at week 12, and every 4 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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