GASTROENTEROLOGY SPECIALTY ENROLLMENT FORM

PATIENT INFORMATION

Last Name ______ First Name ______

Social Security No. ______ Date of Birth ______

Sex ☐ M ☐ F Weight_____ Height _____ Allergies____________

Home Phone ______ Work/Mobile/Phone ______

Home Address ______

City ______ Zip ______

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______ Primary Insurance Phone ______

Subscriber Name ______

Policy Number ______ Group Number ______

Prescription Card BIN # ______ PCN # ______

TREATMENT ARRANGEMENTS

Start Date:_______________ Ship meds: ☐ Home ☐ Doctor's Office

Teaching By: ☐ Doctor's Office ☐ Other:_________________________

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 CODE):

☐ K50.00 Crohn's disease ☐ K51.80 Ulcerative colitis

☐ K58.0 Irritable Bowel Syndrome with Diarrhea (IBS -D)

☐ Other: ______________________________

Date of Diagnosis: ______________________________

Prior (Failed) Medications:

Medication ***Strength*** ***Duration of Treatment/Reason for D/C***

Biologics: ☐ Humira ☐ Enbrel ☐ Remicade ☐ Others: _________

☐ 5-ASA ☐ Azathioprine ☐ Corticosteroids ☐ Methotrexate

☐ 6-MP ☐ Sulfasalazine______________________________

☐ Other______________________________

Patient Evaluation:

☐ Crohn's Severity: ☐ Moderate ☐ Severe

☐ Has TB test been performed ? ☐ Yes ☐ No

If Yes, Results:_______________ Comments:____________________

☐ Is patient at risk for Hepatitis B infection ? ☐ Yes ☐ No

If Yes, has Hepatitis B been ruled out or treatment initiated? ☐ Yes ☐ No

☐ Allergies:______________________________

☐ Concomitant Medications:______________________________

☐ Other______________________________

____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ **Entyvio**	☐ 300mg Vials	☐ 300mg Infused IV over 30 min at week 0, 2, 6 then every 8 weeks.		
☐ **Cimzia**	☐ 200mg/1ml Prefilled syringe ☐ 200mg vial	☐ Induction dose: Inject 400mg(2 vials) subcutaneously on day 1, week 2, week 4.	3Kits (6 vials)	0
		☐ Maint. Dose: Inject 400mg(2 vials) subcutaneously every 4 weeks.		
☐ **Humira**	☐ Crohn's Starter Package	☐ Induction Dose: Inject subcutaneously 160mg on day 1, then 80mg on day 15, then maintenance.	1 Package	0
	☐ 40mg Self Injectable Pen ☐ 40mg Prefilled Syringe	☐ Maint. Dose: Inject subcutaneously 40mg every other week. ☐ Maint. Dose: Inject subcutaneously 40mg every other week.		
☐ **Humira CF** *(Citrate-free)*	☐ Humira Starter Pack CD/UC/HS ☐ 40mg Pen ☐ 40mg Prefilled Syringe	**Weight (>88lbs)** ☐ Induction Dose: Inject subcutaneously 160mg on day 1, then 80mg on day 15, then maintenance. ☐ Maint. Dose: Inject subcutaneously 40mg every other week.		
☐ **Remicade**	☐ 100mg Vials ☐ __________mg/kg	☐ Induction Dose: IV at 5mg/kg (Dose=_____________mg) at 0, 2, and 6 weeks. ☐ Maintenance Dose: IV at 5 mg/kg (Dose=_____________mg) every 8 weeks. ☐ Other:______________________________	_____# of 100mg vial	_____
☐ **Simponi**	☐ 100mg/ml	☐ 200mg SQ at week 0, then 100mg at week 2, then 100mg every 4 weeks thereafter.		
☐ **Stelara**	☐ 130mg/26ml Solution Vials ☐ 90mg/ml Syringe	☐ Initial Dose: Infuse ______ mg x dose. (55kg or less—260mg; 55-85kg—390mg; 85kg or more—520mg) ☐ Maint Dose: Inject 90mg SQ every 8 weeks after initial dose, then every 8 weeks thereafter. ☐ Other:______________________________		
☐ **Xeljanz**	☐ 5mg ☐ 10mg	☐ Take 5mg PO twice daily. ☐ Take 10mg PO twice daily. ☐ Other:______________________________		

Physician Signature: x______________________________ ☐ **DAW (Dispense as Written) Date:** ____________

Physician Name: ______________ **Phone:** ____________ **Fax:** ____________ **Office Contact:** ____________

Physician Address: ______________________________ **NPI:** ____________ **DEA:** ____________

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