

GASTROENTEROLOGY SPECIALTY ENROLLMENT FORM

PATIENT INFORMATION		PATIENT INSURANCE INFORMATION	
Last Name _____	First Name _____	Primary Medical Insurance _____ Primary Insurance Phone _____	
Social Security No. _____	Date of Birth _____	Subscriber Name _____	
Sex <input type="checkbox"/> M <input type="checkbox"/> F Weight _____ Height _____ Allergies _____		Policy Number _____	Group Number _____
Home Phone _____	Work/Mobile/Phone _____	Prescription Card BIN # _____	PCN # _____
TREATMENT ARRANGEMENTS			
Home Address _____		Start Date: _____ Ship meds: <input type="checkbox"/> Home <input type="checkbox"/> Doctor's Office	
City _____	Zip _____	Teaching By: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____	

STATEMENT OF MEDICAL NECESSITY	
<p>Diagnosis (ICD-10 CODE): <input type="checkbox"/> K50.00 Crohn's disease <input type="checkbox"/> K51.80 Ulcerative colitis <input type="checkbox"/> K58.0 Irritable Bowel Syndrome with Diarrhea (IBS -D) <input type="checkbox"/> Other: _____ Date of Diagnosis: _____</p> <p>Prior (Failed) Medications: <u>Medication Strength Duration of Treatment/Reason for D/C</u> Biologics: <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> Remicade <input type="checkbox"/> Others: _____ <input type="checkbox"/> 5-ASA <input type="checkbox"/> Azathioprine <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Methotrexate <input type="checkbox"/> 6-MP <input type="checkbox"/> Sulfasalazine _____ <input type="checkbox"/> Other _____</p>	<p>Patient Evaluation: <input type="checkbox"/> Crohn's Severity: _____ <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Has TB test been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Results: _____ Comments: _____ <input type="checkbox"/> Is patient at risk for Hepatitis B infection? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, has Hepatitis B been ruled out or treatment initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Concomitant Medications: _____ <input type="checkbox"/> Other _____</p>

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

Physician Signature: x _____ DAW (Dispense as Written) Date: _____

Physician Name: _____ Phone: _____ Fax: _____ Office Contact: _____

Physician Address: _____ NPI: _____ DEA: _____

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