

GASTROENTEROLOGY/CROHN'S DISEASE / ULCERATIVE COLITIS PRESCRIPTION ENROLLMENT FORM

PATIENT INFORMATION

Name (First, Last): _____ ☐ Male ☐ Female
Address: _____ City: _____ State: ____ Zip Code: _____
Phone: (____) ____ - ____ Date of Birth (mm/dd/yyyy) : ____ / ____ / ____ Social Security # ____ - ____ - ____

Medication	Dose/Strength	Directions	Quantity	Refill
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200MG	<input type="checkbox"/> Inject 400 mg subcutaneously at weeks 0, 2 and 4 <input type="checkbox"/> Inject 400 mg subcutaneously every 4 weeks	<input type="checkbox"/> Vials <input type="checkbox"/> PFS	
<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300 mg/ 20 ml vial	<input type="checkbox"/> Infuse IV 300 mg weeks 0, 2, 6 <input type="checkbox"/> Infuse IV 300 mg every 8 weeks	<input type="checkbox"/> Vials	
<input type="checkbox"/> Humira	<input type="checkbox"/> 3x 80 mg/0.8 mL Citrate Free Kit <input type="checkbox"/> 6x40 mg/0.8 mL Starter Kit	<input type="checkbox"/> Inject 160 mg subcutaneously on day 1, then 80 mg on day 15 <input type="checkbox"/> Inject 40 mg subcutaneously on day 29 and every other week thereafter	<input type="checkbox"/> Pens <input type="checkbox"/> Syringe	
<input type="checkbox"/> Remicade	<input type="checkbox"/> 100 mg/ 20 ml vial	<input type="checkbox"/> Infuse IV 5 mg/ kg weeks 0, 2, 6 <input type="checkbox"/> Infuse IV 5 mg/ kg every 8 weeks		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 3 x 100 mg/mL <input type="checkbox"/> 1 x 100 mg/mL	<input type="checkbox"/> Inject 200 mg subcutaneously at week 0, then 100 mg at week 2 <input type="checkbox"/> Inject 100 mg subcutaneously cut every 4 weeks	<input type="checkbox"/> PFS <input type="checkbox"/> smartject	
<input type="checkbox"/> Stelara	<input type="checkbox"/> 90 mg/mL	<input type="checkbox"/> Inject 90 mg subcutaneously 8 weeks following initial intravenous dose, then every 8 weeks thereafter	<input type="checkbox"/> PFS	
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg <input type="checkbox"/> 10mg	<input type="checkbox"/> Take 10 mg by mouth twice daily for 8 weeks <input type="checkbox"/> Take 10 mg by mouth twice daily <input type="checkbox"/> Take 5 mg by mouth twice daily	<input type="checkbox"/> 60	
<input type="checkbox"/> Zinplava	<input type="checkbox"/> 10 mg/kg IV	<input type="checkbox"/> Infuse 10 mg/kg IV over 60 minutes as a single dose		

DIAGNOSIS AND CLINICAL INFORMATION

ICD-10 & Diagnosis	Prior Tried/Failed Medications - MUST provide info to avoid prior authorization denials:		
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> Other : _____	Medication/Strength	Duration	Reason for Discontinuation
Is the patient currently on? <input type="checkbox"/> YES <input type="checkbox"/> NO Dosage: _____ Does Patient have a latex allergy? <input type="checkbox"/> YES <input type="checkbox"/> NO Height: _____ in/ft Weight: _____ lb/kg TB/PPD test completed? <input type="checkbox"/> YES <input type="checkbox"/> NO Date: ____/____/____ Results: _____			
<input type="checkbox"/> NKDA or Allergies: _____			

Total # of Dangerous Drugs Prescribed _____

PRESCRIBER'S INFORMATION

Prescriber Name (First, Last): _____ NPI #: _____
Address: _____ DEA #: _____
City: _____ State: ____ Zip Code: _____
Phone: (____) ____ - ____ Fax: (____) ____ - ____ Contact Name: _____

Physician Signature: _____ Date: ____ / ____ / ____

I authorize 986 Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.