986 PHARMACY SPECIALTY

1719 E. Walnut St.
Pasadena, CA 91106
Tel: 626-798-6789
FAX: 626-798-8376

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
☐ Cimzia	☐ 200MG	☐ Inject 400 mg subcutaneously at weeks 0, 2 and 4 ☐ Inject 400 mg subcutaneously every 4 weeks	☐ Vials ☐ PFS	
☐ Entyvio	☐ 300 mg/ 20 ml vial	☐ Infuse IV 300 mg weeks 0, 2, 6 ☐ Infuse IV 300 mg every 8 weeks	☐ Vials	
☐ Humira	☐ 3x 80 mg/0.8 mL Citrate Free Kit ☐ 6x40 mg/0.8 mL Starter Kit	☐ Inject 160 mg subcutaneously on day 1, then 80 mg on day 15 ☐ Inject 40 mg subcutaneously on day 29 and every other week thereafter	☐ Pens ☐ Syringe	
☐ Remicade	☐ 100 mg/ 20 ml vial	☐ Infuse IV 5 mg/ kg weeks 0, 2, 6 ☐ Infuse IV 5 mg/ kg every 8 weeks		
☐ Simponi	☐ 3 x 100 mg/mL ☐ 1 x 100 mg/mL	☐ Inject 200 mg subcutaneously at week 0, then 100 mg at week 2 ☐ Inject 100 mg subcutaneously cut every 4 weeks	☐ PFS ☐ smartject	
☐ Stelara	☐ 90 mg/mL	☐ Inject 90 mg subcutaneously 8 weeks following initial intravenous dose, then every 8 weeks thereafter	☐ PFS	
☐ Xeljanz	☐ 5mg ☐ 10mg	☐ Take 10 mg by mouth twice daily for 8 weeks ☐ Take 10 mg by mouth twice daily ☐ Take 5 mg by mouth twice daily	☐ 60	
☐ Zinplava	☐ 10 mg/kg IV	☐ 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:*
☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ Other :	Medication/Strength Duration Reason for Discontinuation Is the patient currently on? ☐ YES ☐ NO Dosage: _____ Does Patient have a latex allergy? ☐ YES ☐ NO Height: _____ in/ft Weight: _____ lb/kg TB/PPD test completed? ☐ YES ☐ NO Date: ___ ___/___ ___/___ ___ Results:
☐ 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