VITAL CARE RX

Tailored Therapy, Trusted Care

GI Enrollment Form

Phone: (877)229-1724 l Fax: (877)229-1725

PATIENT INFORMATION

(Complete the following or send patient demographic sheet.)
Please fax copy of patient's insurance card including both sides

Name:____________________
DOB:__________ Gender: M / F Height: ______Wt:________
Address:____________________
City, State, Zip:____________________
Home Phone:____________________
Alternate Phone:____________________
Last 4 digits SS#:____________ Email: ____________

PRESCRIBER INFORMATION

Prescriber Name: ____________________
State Lic. #: __________ NPI:__________
Facility Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Phone: __________ Fax: __________
Contact: ____________________
Phone: __________Email: __________

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

☐ K50.90 Crohn's disease NOS ☐ K51.90 Ulcerative Colitis ☐ Other: ____________

Please indicate current or previous treatments and treatment duration below:

☐ NSAIDS Duration: __________ ☐ Corticosteroids Duration: __________
☐ Methotrexate Duration: __________ ☐ Azathioprine Duration: __________
☐ Sulfasalazine Duration: __________ ☐ 5 – ASA Duration: __________
☐ 6 – MP Duration: __________ ☐ Other: Duration: __________

Other medications patient is currently taking:____________________
TB/PPD Test given? ☐ Yes ☐ No Date: ________ Results:________ Allergies: ____________
BSA:____________________
Expected date of first/next dose: ____________ Date of last dose: ____________

PRESCRIPTION INFORMATION

Medication		Directions	Quantity	Refills
Cimzia®	☐ Starter Kit ☐ Prefilled Syringe ☐ Lyophilized Powder	☐ **Initial dose:** Inject 400 mg SC at week 0, week 2, and week 4 ☐ **Maintenance dose:** Inject 400 mg SC every 4 weeks	1 starter kit 28 day supply	0
Entyvio®	☐ 300 mg vial	☐ **Initial Dose:** Infuse 300mg IV over 30 minutes at week 0, week 2 and week 6 ☐ **Maintenance dose:** Infuse 300mg IV over 30 minutes every 8 weeks	Initial dose QS	
Humira®	☐ Starter Kit ☐ 40 mg Pen ☐ 40 mg Prefilled Syringe	☐ **Initial Dose:** Inject 160 mg (4 pens) SC on day 1, 80 mg (2 pens) on day 15, then 40 mg thereafter beginning on day 29 ☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC once a week	1 starter kit 28 day supply	0
Remicade®	☐ 100 mg vial	☐ **Initial Dose:** Infuse _____mg/kg (______mg) IV at weeks 0, 2, and 6 weeks. ☐ **Maintenance Dose:** Infuse _____mg/kg (______mg) IV every ____ weeks.	QS	
Simponi®	☐ 100 mg SmartJect ☐ 100 mg Prefilled Syringe	☐ **Initial Dose:** Inject 200mg SC at week 0, then 100mg at week 2, then maintenance dose ☐ **Maintenance Dose:** Inject 100mg SC once every 4 weeks	3 units 28 day supply	0
Stelara®	☐ 130 mg vial	**Initial Dose:** Infuse IV over at least 1 hour. ☐ ≤ 121 lbs 260 mg (2 vials) ☐ > 121 lbs to 187 lbs 390 mg (3 vials) ☐ > 187 lbs 520 mg (4 vials)	QS	0
	☐ 90mg Prefilled Syringe	☐ **Maintenance Dose:** Inject 90 mg SC 8 weeks after initial IV infusion, then every 8 weeks thereafter	QS	
Xifaxan®	☐ 550mg Tablet	☐ Take 1 tablet by mouth 3 times a day	42	0
Other:				

Special Instructions: ____________________

Ship Medications To: ☐ **Physician's Clinic** ☐ **Patient's Home** **Injection Training Needed:** ☐ **Yes** ☐ **No**

Prescriber Signature ____________________ Date__________ Brand Name Required? ☐Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.