VITAL CARE RX

Tailored Therapy, Trusted Care

GI Enrollment Form

Phone: (877)229-1724 | 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: 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 PFS ☐ Starter Kit CF ☐ 40 mg CF Pen ☐ 40 mg CF Prefilled Syringe	☐ **Initial Dose:** Inject 160 mg SC on day 1, 80 mg 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	
Xeljanz®	☐ 5 mg tabs ☐ 10 mg tabs	☐ **Initial Dose:** Take 10 mg PO BID for 8 weeks ☐ **Maintenance Dose:** Take 5 mg PO BID ☐ **Maintenance Dose:** Take 10 mg PO BID		
Xifaxan®	☐ 550mg Tablet	☐ Take 1 tablet by mouth 3 times a day	42	0
Other:				

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.