VITAL INFORMATION

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: 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 ☐ K20.00 Eosinophilic Esophagitis ☐ Other: _____

Please indicate current or previous treatments and treatment duration below:

☐ NSAIDS Duration: _____
☐ Methotrexate Duration: _____
☐ Sulfasalazine Duration: _____
☐ 6 - MP Duration: _____
☐ Corticosteroids Duration: _____
☐ Azathioprine Duration: _____
☐ 5 - ASA 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	0
Dupixent®	☐ **300mg/Prefilled Pen** ☐ **300mg/Prefilled Syringe**	☐ Inject 300 mg SC once a week	28 day supply 28 day supply	
Entyvio®	☐ 300 mg vial	☐ **Initial Dose:** Infuse 300mg IV over 30 minutes at week 0, week 2 and week 6 ☐ **Maintenance:** Infuse 300mg IV over 30 minutes every 8 weeks	Initial Dose QS	
Humira® *Citrate Free*	☐ Crohn's/UC Starter Kit ☐ 40 mg Pen ☐ 40 mg PFS	☐ **Initial Dose:** Inject 160 mg SC on day 1, 80 mg on day 15, then 40 mg, thereafter beginning on day 29 ☐ **Maintenance:** ☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC once a week	1 starter kit 28 day supply	0
Humira® *Citrate Free Pediatric*	☐ Pediatric Crohn's Starter	☐ **Initial Dose:** **Weight 17-39kg** Inject 80 mg SC on day 1, 40 mg on day 15, then 20 mg thereafter beginning on day 29	1 starter kit	0
	☐ 20mg PFS	☐ **Maintenance:** Inject 20 mg SC every other week	28 day supply	
	☐ Pediatric UC Starter	☐ **Initial Dose: Weight 20-39kg** Inject 80 mg SC on day 1, 40 mg on day 8, then 40 mg on day 15 ☐ **Initial Dose Weight 40kg** Inject 160 mg SC on day 1, 80 mg on day 8, then 80 mg on day 15	1 starter kit	0
	☐ 20 mg PFS ☐ 40 mg PFS ☐ 40 mg Pen ☐ 80 mg Pen	**Maintenance: Weight 20-39kg** ☐ Inject 40 mg SC every other week beginning on day 29 ☐ Inject 20 mg SC every week beginning on day 29 **Maintenance: Weight 40kg** ☐ Inject 80 mg SC every other week beginning on day 29 ☐ Inject 40 mg SC every week beginning on day 29	28 day supply	
Remicade®	☐ 100 mg vial	☐ **Initial Dose:** Infuse _____mg/kg (_____mg) IV at weeks 0, 2, and 6 weeks ☐ **Maintenance:** Infuse _____mg/kg (_____mg) IV every _____ weeks	QS	
Rinvoq®	☐ Starter Kit: 45 mg ☐ 15 mg ☐ 30 mg	☐ **Initial Dose:** Take 45mg po once a day for ___weeks ☐ **Maintenance:** Take po once a day	28 30	
Simponi®	☐ 100 mg SmartJect ☐ 100 mg PFS	☐ **Initial Dose:** Inject 200mg SC at week 0, then 100mg at week 2, then maintenance dose ☐ **Maintenance:** 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) ☐ > 187 lbs 520 mg (4 vials) ☐ > 121 lbs to 187 lbs 390 mg (3 vials)	QS	0
	☐ 90mg Prefilled Syringe ☐ 90mg vial (2x 45mg vials)	☐ **Maintenance:** Inject 90 mg SC 8 weeks after initial IV infusion, then every 8 weeks thereafter	QS	
Skyrizi®	☐ 600 mg vial	☐ **Initial Dose:** Infuse 600 mg IV over at least 1 hour on week 0, 4 and 8	1	2
	☐ 360 mg PF on-body injector ☐ 180 mg PF on-body injector	☐ **Maintenance:** Inject at week 12, and every 8 weeks thereafter	1	
Tremfya®	☐ IV Starter Dose: 200mg ☐ 100mg/mL One Press ☐ 100mg/mL Prefilled syringe ☐ 200mg/2mL Prefilled pen ☐ 200mg/mL Prefilled syringe	☐ **Initial Dose:** 200mg IV at week 0, 4 and 8 (one-hour infusion) ☐ **SUBQ Induction Regimen:** 400 mg SC (as 2 consecutive 200 mg injections) on weeks 0, 4, and 8 ☐ **Maintenance:** Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter ☐ **Maintenance:** Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter		
Xeljanz®	☐ 5 mg tabs	☐ **Initial Dose:** Take 10 mg PO BID for 8 weeks	60	0
	☐ 10 mg tabs	**Maintenance:** ☐ Take 5 mg PO BID ☐ Take 10 mg PO BID	60	
Xeljanz XR®	☐ 11 mg tabs	☐ **Initial Dose:** Take 22 mg by mouth once daily for 8 weeks	30	0
	☐ 22 mg tabs	**Maintenance:** ☐ Take 11 mg by mouth once daily ☐ Take 22 mg by mouth once daily	30	
Xifaxan®	☐ 550mg Tablet	☐ Take 1 tablet by mouth twice a day	60	
Zeposia®	☐ 7 Day Titration Pack	☐ **Initial Dose:** Take as directed on Titration Pack	1	
	☐ 0.92 Capsules	☐ **Maintenance:** Take 1 capsule by mouth once a day beginning day 8	30	
Other:				

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

Prescriber Signature _____ **Date** _____ **Brand Name Required?** ☐ **Yes** ☐ **No**

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 insurers provider network.