

GASTROENTEROLOGY ENROLLMENT FORM

PATIENT INFORMATION			
Patient Name:		Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			
Phone:		Alternate Phone:	
Height:	Weight:	Allergies:	Allergy to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSIS	
Date of diagnosis: _____	
Crohn's Disease: <input type="checkbox"/> K50.0__ (Of Small Intestine) <input type="checkbox"/> K50.1__ (Of Large Intestine) <input type="checkbox"/> K50.8__ (Crohn's Disease of Both Intestines) <input type="checkbox"/> K50.9__ (Crohn's Disease, Unspecified)	
Ulcerative Colitis: <input type="checkbox"/> K51.0__ (Ulcerative Pancolitis) <input type="checkbox"/> K51.2__ (Ulcerative Proctitis) <input type="checkbox"/> K51.3__ (Ulcerative Rectosigmoiditis) <input type="checkbox"/> K51.5__ (Left Sided Colitis) <input type="checkbox"/> K51.8__ (Other Ulcerative Colitis) <input type="checkbox"/> K51.9__ (Ulcerative Colitis, unspecified)	
IBS with diarrhea <input type="checkbox"/> K58.0 IBS with constipation <input type="checkbox"/> K58.1 Drug-induced constipation <input type="checkbox"/> K59.03 Chronic idiopathic constipation <input type="checkbox"/> K59.04 Hepatic Encephalopathy <input type="checkbox"/> K72. Other <input type="checkbox"/> (ICD-10 : _____)	

CLINICAL INFORMATION	
Date of TB test: _____ Results: <input type="checkbox"/> negative <input type="checkbox"/> pending Treatment History: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Drug change Failed Therapies: <input type="checkbox"/> Corticosteroids <input type="checkbox"/> 6-MP <input type="checkbox"/> 5-ASA <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Linzess <input type="checkbox"/> Fiber <input type="checkbox"/> Stimulants <input type="checkbox"/> Laxative <input type="checkbox"/> Osmotic laxative	Current therapy: _____ Stop before starting new therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Withhold for how long before starting: _____

DRUG	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> AMITIZA <input type="checkbox"/> 8 mcg (IBS-C) <input type="checkbox"/> 24 mcg (CIC)	<input type="checkbox"/> Take 1 capsule PO twice daily		
<input type="checkbox"/> CIMZIA <input type="checkbox"/> 200 mg vial <input type="checkbox"/> 200 mg PFS	<input type="checkbox"/> Loading dose: Inject 400 mg (two 200 mg injections) SQ on weeks 0, 2, and 4, then maintenance Maintenance dose: <input type="checkbox"/> 400 mg (two 200 mg injections) SQ every 4 weeks <input type="checkbox"/> 200 mg SQ every 2 weeks	6	0
<input type="checkbox"/> ENTYVIO 300 mg vial	<input type="checkbox"/> Loading dose: Infuse 300 mg at weeks 0, 2, and 6, then once every 8 weeks <input type="checkbox"/> Maintenance dose: Infuse 300 mg every 8 weeks	3	0
<input type="checkbox"/> HUMIRA Citrate Free <input type="checkbox"/> Humira 80mg loading dose pen kit <input type="checkbox"/> 20 mg PFS (<40 kg) <input type="checkbox"/> 40 mg PFS <input type="checkbox"/> 40 mg Pen	Initial dose: <input type="checkbox"/> Inject 80 mg SQ on day one, 40 mg on day 15, then begin maintenance <input type="checkbox"/> Inject 160 mg SQ on day one, 80 mg on day 15, then begin maintenance <input type="checkbox"/> Inject 80 mg SQ on day 1, day 2, and day 15, then begin maintenance Maintenance dose: <input type="checkbox"/> Inject 20 mg SQ every 2 weeks <input type="checkbox"/> Inject 40 mg SQ every 2 weeks <input type="checkbox"/> Inject 40 mg SQ weekly		0
<input type="checkbox"/> LINZESS <input type="checkbox"/> 72 mcg (CIC) <input type="checkbox"/> 145 mcg (CIC) <input type="checkbox"/> 290 mcg (IBS-C)	<input type="checkbox"/> Take 1 capsule PO once daily at least 30 minutes prior to first meal of the day		
<input type="checkbox"/> REMICADE 100 mg vial	<input type="checkbox"/> Loading dose: Infuse _____ mg IV on: week 0, week 2, and week 6, then maintenance <input type="checkbox"/> Maintenance dose: Infuse _____ mg IV every ____ weeks		0
<input type="checkbox"/> RELISTOR <input type="checkbox"/> 8 mg PFS <input type="checkbox"/> 12 mg PFS <input type="checkbox"/> 150 mg tablet	<input type="checkbox"/> Inject one PFS SQ once daily <input type="checkbox"/> Take three tablets (450 mg) PO once daily in the morning		
<input type="checkbox"/> SIMPONI <input type="checkbox"/> 100 mg PFS <input type="checkbox"/> 100 mg Smartject pen	<input type="checkbox"/> Loading dose: Inject 200 mg SQ at week 0, 100 mg at week 2, then begin maintenance at week 6 <input type="checkbox"/> Maintenance dose: Inject 100 mg SQ every 4 weeks	3	0
<input type="checkbox"/> STELARA <input type="checkbox"/> 130 mg vial <input type="checkbox"/> 45 mg PFS <input type="checkbox"/> 90 mg PFS	<input type="checkbox"/> Initial dose: Infuse _____ mg IV as single dose, then begin maintenance dose 8 weeks later <input type="checkbox"/> Maintenance dose: Inject one PFS SQ every 8 weeks		
<input type="checkbox"/> TRULANCE 3 mg tablets	Take 1 tablet (3 mg) PO once daily		
<input type="checkbox"/> UCERIS <input type="checkbox"/> 9 mg XR tablet <input type="checkbox"/> 2 mg rectal foam	<input type="checkbox"/> Take 1 tablet (9 mg) by mouth once daily in the morning for up to 8 weeks <input type="checkbox"/> Apply 1 metered dose twice daily rectally for 2 weeks, then 1 dose every evening for 4 weeks	56	0
<input type="checkbox"/> XELJANZ <input type="checkbox"/> 22 mg XR tablet <input type="checkbox"/> 10 mg tablet <input type="checkbox"/> 11 mg XR tablet <input type="checkbox"/> 5 mg tablet	Induction dose: <input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Take 1 tablet by mouth twice daily Maintenance dose: <input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Take 1 tablet by mouth twice daily		
<input type="checkbox"/> XIFAXAN 550 mg tablet	<input type="checkbox"/> Hepatic encephalopathy: Take 1 tablet (550 mg) PO twice daily <input type="checkbox"/> IBS-D: Take 1 tablet (550 mg) PO three times daily for 14 days		
<input type="checkbox"/> OTHER:			

<input type="checkbox"/> Patient is ready to start treatment, contact patient for delivery		<input type="checkbox"/> Ship all orders to office		<input type="checkbox"/> Ship first order to office, subsequent orders to patient	
SIGNATURE			DATE:		
PHYSICIAN NAME:		DEA #:	NPI #:		STATE LICENSE #:
PRACTICE NAME:		ADDRESS:		CITY, STATE:	ZIP:
PHONE #:		FAX:		OFFICE CONTACT:	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified.