P: 832-813-8932

F: 888-883-9901

GASTROENTEROLOGY RX FORM

PATIENT INFORMATION

PATIENT NAME: _____ **DOB** _____/_____/_____ **PHONE:** (_____) - _____ - _____

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS

MEDICATION

☐ CIMZIA 400MG SQ AT WEEKS 0, 2, 4 AND THEN EVERY 4 WEEKS
☐ CIMZIA _____ MG SQ EVERY _____ WEEKS

☐ ENTYVIO 300 MG IV AT WEEKS 0, 2, 6 AND THEN EVERY 8 WEEKS
☐ ENTYVIO 300 MG IV EVERY _____ WEEKS

☐ REMICADE _____MG/KG IV AT WEEKS 0, 2, 6, AND EVERY 8 WEEKS
☐ REMICADE _____MG/KG IV EVERY _____ WEEKS
*PREMEDICATE: TYLENOL 500MG PO, ZYRTEC 10MG PO

☐ STELARA SINGLE IV DOSE ☐260MG (<55KG)
☐390MG (55KG-85KG)
☐520MG (>85KG+)

☐ STELARA 90 MG SQ EVERY _____ WEEKS

☐ TYSABRI 300MG IV EVERY 4 WEEKS

☐ ZINPLAVA 10MG/KG IV SINGLE IV

REFILLS
☐ 1 YEAR
☐ _____

PRE-MEDICATIONS

BENADRYL IV _____ MG
REGLAN IV _____ MG
SOLUMEDROL IV _____ MG
ZOFRAN IV _____ MG
OTHER IV _____ MG

BENADRYL PO _____ MG
TYLENOL PO _____ MG
ZYRTEC PO _____ MG
ZOFRAN PO _____ MG
ZANTAC PO _____ MG
OTHER PO _____ MG

IF APPLICABLE, DATE OF LAST INFUSION: _____

WILL PATIENT BE RE-LOADING? ☐**YES** ☐**NO**

MEDICAL INFORMATION

WEIGHT: _____**LBS** **HEIGHT:** _____ **IN**
ALLERGIES: _____ ☐ **N.K.D.A**

DATE OF TB EXAM (CIMZIA, REMICADE, STELARA, ENTYVIO): _____
METHOD: ☐ **CXR** ☐ **QFT** ☐ **PPD**
RESULT: ☐ **NEGATIVE** ☐ **POSITIVE**

DATE OF HEP PANEL (CIMZIA, REMICADE): gjiyad
RESULT: ☐ **NEGATIVE** ☐ **POSITIVE**

DATE OF C. DIFF STOOL TEST (ZINPLAVA ONLY): _____
RESULT: ☐ **NEGATIVE** ☐ **POSITIVE**

DATE OF JCV ANTIBODY (TYSABRI ONLY): _____
RESULT: ☐ **NEGATIVE** ☐ **POSITIVE**

PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1 _____ **DATE RANGE:** _____

#2 _____ **DATE RANGE:** _____

#3 _____ **DATE RANGE:** _____

PATIENT WILL BE DISCONTINUING: _____

PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES

DIAGNOSIS

ULCERATIVE COLITIS

☐ K51.00 ULC (CHRONIC) PANCOLITIS W/O COMPLICATIONS
☐ K51.20 ULC (CHRONIC) PROCTITIS W/O COMPLICATIONS
☐ K51.30 ULC (CHRONIC) RECTOSIGMOIDITIS W/O COMPLICATIONS
☐ K51.50 LEFT-SIDED COLITIS W/O COMPLICATIONS
☐ K51.80 OTHER ULC COLITIS W/O COMPLICATIONS
☐ K51.90 ULC COLITIS, UNSP, W/O COMPLICATIONS

CROHN'S DISEASE

☐ K50.00 CROHN'S DIS OF SMALL INT W/O COMPLICATIONS
☐ K50.10 CROHN'S DIS OF LARGE INT W/O COMPLICATIONS
☐ K50.80 CROHN'S DIS OF BOTH SM/LG INT W/O COMPLICATIONS
☐ K50.90 CROHN'S DIS, UNSP, W/O COMPLICATIONS
☐ K50.01____ CROHN'S DIS OF SMALL INT W COMPLICATIONS
☐ K50.81____ CROHN'S DIS OF BOTH SM/LG INT W COMPLICATIONS
☐ K50.91____ CROHN'S DIS, UNSP, W COMPLICATIONS
☐ K50.11 ____ CROHN'S DIS OF LARGE INT W COMPLICATIONS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN NAME (PRINTED): _____ **NPI:** _____

PHONE: _____ **FAX:** _____ **CONTACT PERSON:** _____

PHYSICIAN NAME (SIGNED): _____ **DATE:** _____

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