



GASTROENTEROLOGY ENROLLMENT FORM

Fax to: 817-332-5363

PHARMACY LOCATION
Phone: 817-335-5712
Fax: 817-332-5363
800 8th Avenue, Suite 130
Fort Worth, TX 76104

DATE: _____ SHIP TO:
DATE NEEDED: _____ PATIENT OFFICE

PATIENT INFO
NAME _____ E-MAIL _____ DOB _____ MALE FEMALE
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK) PRESCRIPTION INFORMATION

Diagnosis Codes

Date of Diagnosis: _____
 K50.00 Crohn's Disease K51.80 Ulcerative Colitis
 K76.82 HE Other: _____

TREATMENT HISTORY

New to this medicine Continued Treatment
If continuing treatment, has patient's condition improved or stabilized? Yes No
Patient Weight: _____ kg/lb
Allergies? NKDA Latex Other: _____
Concomitant Medications: _____
Crohn's/UC Severity: Severe Moderate Mild
Presence of Enterocutaneous/ Rectovaginal Fistulas? Yes No
Has patient been diagnosed with Heart Failure? Yes No
Has patient been diagnosed with Lymphoma? Yes No
Does patient have serious/active infection? Yes No
TB/PPD Test Results? Yes No Result: _____
Is patient at risk for Hepatitis B infection? Yes No If Yes, has Hepatitis B been ruled out or treatment started? Yes No
Other: _____

PRIOR FAILED MEDICATION(S)

Medication _____
Length of Treatment _____ to _____
Reason for Discontinuing _____
Medication _____
Length of Treatment _____ to _____
Reason for Discontinuing _____
Manufacturer's Support: Is patient enrolled in the product manufacturer's sponsored support program? (e.g., myHUMIRA, AccessOne) Yes No

Other Prescription

Drug Name: _____
 Strength: _____
 Directions: _____
QTY: _____ Refills _____

- Remicade® 100mg SDV (Crohn's/UC)
- Inflectra® 100mg/20ml vial (Crohn's/UC)
- Renflexis® 100mg SDV (Crohn's/UC)
- Avsola® 100mg SDV (Crohn's/UC)
- Infliximab 100mg SDV (Crohn's/UC)

Initial Directions:
 Administer _____ mg (5mg/kg) at Weeks 0, 2, & 6, then maintenance dosing. QTY: _____ Vials
Other: _____

Maintenance Directions:
 Administer _____ mg every 8 wks QTY: _____ Vials
Other: _____ Refills _____

■ Cimzia® (Crohn's)

Initial Dose: Starter Kit (200mg Pre-filled Syringe) Vial (200mg/ml) & supplies
Initial Directions: Inject 400mg SC at weeks 0, 2, and 4.
 Other: _____ QTY: _____

Maintenance Dose:
 Pre-filled Syringe (200mg/ml) Vial (200mg/ml) & supplies
Maintenance Directions: Inject 400mg SC every 4 weeks.
 Other: _____ QTY: 2 pre-filled syr 4 Vials _____ Refills _____

■ Entyvio® (Crohn's/UC)

300mg/20ml Vial
Initial Directions:
 Administer 300mg via IV infusion at Weeks 0, 2, and 6, then 300mg every 8 weeks.
 Other: _____ Vials

Maintenance Directions:
 Administer 300mg via IV infusion every 8 wks.
 Other: _____ Vials | Refills _____

■ Xifaxan®

550mg 200mg
Hepatic Encephalopathy: Sig. Take 1 Tab PO BID
IBS-D: Sig. Take 1 Tab PO TID
 Other: _____
QTY: _____ Refills _____

■ Rinvoq®

Initial Dose (Crohn's):
 45mg ER Tablet QD x 12 weeks. Qty: 28 tablets
Refills: 2
Initial Dose (UC):
 45mg ER Tablet QD x 8 weeks Qty: 28 tablets
 30mg ER Tablet QD x 8 weeks Qty: 30 tablets
Refills: 1

Maintenance Dose (Crohn's / UC):
 15mg ER Tablet Take 1 tablet QD
 30mg ER Tablet Take 1 tablet QD
QTY: 30 Tablets | Refills _____

■ Zeposia® (UC)

Initial Dose:
 0.23/0.46 Capsule Starter Kit (7 day)
QTY: 1 Starter Kit (7 Capsules)
Initial Directions:
Days 1-4: Take 0.23mg by mouth once daily. Days 5-7: Take 0.46mg by mouth once daily.

Maintenance Dose: 0.92mg capsule
Maintenance Directions:
Day 8 and thereafter: Take 1 capsule (0.92mg) by mouth QD
QTY: 30 capsules | Refills _____

■ Humira® (Adult Crohn's/UC)

Initial Dose:
 CD/UC Starter Pack 80mg/0.8mL (CF) (3-Pens)
 CD/UC Starter Pack 80mg/0.8mL (CF) (3-PFS)
 CD/UC Starter Pack 40mg/0.8mL (6 Pens)
 CD/UC Starter Pack 40mg/0.8mL (6 PFS)

Initial Directions:
 Inject 160 mg SC on Day 1, 80 mg on Day 15, then continue with maintenance dose starting Day 29
 Inject 80 mg SC on Day 1, 80 mg on Day 2, 80 mg on Day 15, then continue with maintenance dose starting Day 29
 Other: _____ QTY: _____

Maintenance Dose:
 40mg/0.4mL (CF) Pen 40mg/0.8mL Pen
 40mg/0.4mL (CF) PFS 40mg/0.8mL PFS

Maintenance Directions:
 Inject 40mg SC every OTHER week.
 Other: _____ QTY: 2 _____ Refills _____

■ Humira® (Pediatric Crohn's)

Initial Dose:
17 kg (37 lbs) to less than 40 kg (88 lbs); ≥ 6 yrs:
 80 mg/0.8 mL, 40 mg/0.4 mL PFS Kit
Initial Directions:
 Inject 80 mg SC on Day 1, then 40 mg Day 15, then continue with maintenance dose starting Day 29
QTY: 1 KIT | Refills _____

Maintenance Dose: 20mg/0.2mL (CF) PFS
Maintenance Directions:
 Inject 20mg SC every other week.
QTY: 2 Pens/PFS | Refills _____

■ Initial Dose: 40 kg (88 lbs) and greater; ≥ 6 yrs

CD/UC Starter Pack 80mg/0.8mL (CF) (3-Pens)
 CD/UC Starter Pack 80mg/0.8mL (CF) (3-PFS)
 CD/UC Starter Pack 40mg/0.8mL (6 Pens)
 CD/UC Starter Pack 40mg/0.8mL (6 PFS)

Initial Directions:
 Inject 160 mg SC on Day 1, 80 mg on Day 15, then continue with maintenance dose starting Day 29
 Inject 80mg SC on Day 1, 80mg on Day 2, 80mg on Day 15, then continue with maintenance dose starting Day 29
 Other: _____ QTY: 1 KIT | Refills _____

Maintenance Dose:
 40mg/0.4mL (CF) Pen 40mg/0.8mL Pen
 40mg/0.4mL (CF) PFS 40mg/0.8mL PFS

Maintenance Directions:
 Inject 40mg SC every other week
 Other: _____ QTY: 2 Pens/PFS | Refills _____

■ Skyrizi® (Crohn's)

Initial Dose: 600 mg/10ml Single Dose Vial
Initial Directions: Administer 600mg via IV infusion over at least one hour at Week 0, 4, and 8.
QTY: 1 vial

Maintenance Dose:
 180mg/1.2mL SD Prefilled Cartridge
 360mg/2.4mL SD Prefilled Cartridge

Maintenance Directions:
 Inject 180mg SC at Week 12, then every 8 weeks thereafter.
 Inject 360mg SC at Week 12, then every 8 weeks thereafter.
 Other: _____ QTY: 1 cartridge 3 cartridges | Refills _____

■ Simponi® (UC)

SmartJect Pen (100mg/ml)
 PFS Syringe (100mg/ml)
Initial Directions:
 Inject 200mg (2Pen/PFS) SC at Week 0, then 100mg (1Pen/PFS) SC at Week 2, then 100mg every 4 weeks thereafter.
QTY: 3pen/PFS

Maintenance Directions:
 Inject 100mg (1 Pen/PFS) SC every 4 weeks
QTY: 1 Pens/PFS
 _____ Refills _____

■ Methotrexate

2.5 mg tablets 25 mg/ml Vials
Dosing: _____
QTY: _____ Refills _____

■ Humira® (Pediatric UC)

Initial Dose:
20 kg (44 lbs) to less than 40 kg (88 lbs); ≥ 5 yrs:
 40mg/0.4mL (CF) Pen 40mg/0.8mL Pen
 40mg/0.4mL (CF) PFS 40mg/0.8mL PFS
Initial Directions: Inject 80 mg SC on Day 1, 40 mg on Day 8 and Day 15, then continue with maintenance dose starting Day 29
QTY: 4 Pens 4 Pens/PFS | Refills _____

Maintenance Dose:
 40mg/0.4mL (CF) Pen 20mg/0.2mL (CF) PFS
 40mg/0.4mL (CF) PFS

Maintenance Directions:
 Inject 20mg SC every week
 Inject 40mg SC every other week
 Other: _____ QTY: 1 month 3 month | Refills _____

■ Initial Dose: 40 kg (88 lbs) and greater; ≥ 5 yrs

Starter Pack 80mg/0.8mL (CF) Pen
Initial Directions:
 Inject 160mg SC on Day 1, 80mg on Day 8 and Day 15, then continue with maintenance dose starting Day 29
 Inject 80mg SC on Day 1, Day 2, Day 8, and Day 15, then continue with maintenance dose starting Day 29
QTY: 4 Pens | Refills _____

Maintenance Dose:
 80mg/0.8mL (CF) Pen 40/0.4mL (CF) PFS
 40mg/0.4mL (CF) Pen

Maintenance Directions:
 Inject 40mg SC every week
 Inject 80 SC every other week
 Other: _____ QTY: 1 month 3 month | Refills _____

■ Stelara® (Crohn's / UC)

Initial Dose: Vial (130mg/26ml) for IV Admin.
Initial Directions:
 (wt < 55 kg): Administer 260 mg (2 Vials) as a single dose via IV infusion, then begin maintenance dosing eight weeks later.
 (wt 56 kg to 85 kg): Administer 390 mg (3 Vials) as a single dose via IV infusion, then begin maintenance dosing eight weeks later.
 (wt > 85 kg): Administer 520 mg (4 Vials) as a single dose IV, then begin maintenance dosing eight weeks later. QTY: _____ Vials

Maintenance Dose: 90mg/ml PFS
Maintenance Directions:
 Inject 1 PFS (90mg) SC every 8 weeks.
QTY: _____ PFS | Refills _____

■ Xeljanz® (UC)

Initial Dose: 10mg Tablet 22mg XR Tab let
Initial Directions:
 Take 1 tablet (10mg) by mouth BID.
 Take 1 tablet (22mg XR) by mouth QD.
QTY: 60 30 _____ Refills _____

Maintenance Dose:
 11mg XR Tablet 5mg Tablet
Maintenance Directions:
 Take 1 tablet (5mg) by mouth BID.
 Take 1 tablet (11mg XR) by mouth QD.
 Other: _____ QTY: 60 30 _____ Refills _____

INJECTION TRAINING Patient has received injection training Physician Office to provide injection training Pharmacy to provide injection training

PRESCRIBER INFORMATION
Prescriber's Name: _____ Contact Person: _____
Telephone: _____ Fax: _____ Email: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI #: _____ DEA #: _____ Tax ID #: _____ Medicaid Provider #: _____

PRESCRIBER'S SIGNATURE _____ (DATE) _____ *IF BRAND DRUGS ARE PREFERRED, HANDWRITE "BRAND MEDICALLY NECESSARY" ABOVE
I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process. ©Encore, LP All rights Reserved

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