



Rx Order Form

Gastroenterology

Fax Form to (626) 999-3236

Patient Information		Prescriber Information	
Patient Name: _____		Prescriber Name: _____	
Address: _____		Address: _____	
City, State, Zip: _____		City, State, Zip: _____	
Home Phone: _____		Phone: _____ Fax: _____	
Cell Phone: _____		DEA: _____ NPI: _____	
DOB: _____ Gender: ☐ M ☐ F		Contact Person: _____	
Weight: _____ lbs.	Allergies: ☐ NKDA ☐ Specify: _____		
Insurance Information			
(Please fax a copy of both sides for both pharmacy and medical cards)			
Primary Insurance: _____	ID#: _____	Group: _____	
Secondary Insurance: _____	ID#: _____	Group: _____	
Prescription Card: _____	ID#: _____	BIN#: _____	PCN#: _____ Group: _____
Diagnosis / ICD-10			
(Please fax relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization)			
Primary Diagnosis: _____		ICD-10: _____	
Secondary Diagnosis: _____		ICD-10: _____	
Medication Order			
☐ Cimzia® (certolizumab pegol)		☐ Skyrizi® (risankizumab-rzaa)	
☐ Dupixent® (dupilumab)		☐ Stelara® (ustekinumab)	
☐ Entyvio® (vedolizumab)		☐ Tremfya® (guselkumab)	
☐ Epclusa® (sofosbuvir/velpatasvir)		☐ Vemlidy® (tenofovir alafenamide)	
☐ Humira® (adalimumab)		☐ Xeljanz® (tofacitinib)	
☐ Linzess® (linaclotide)		☐ Xeljanz XR® (tofacitinib extended release)	
☐ Remicade® (infliximab)		☐ Xifaxan® (rifaximin)	
☐ Rinvoq® (upadacitinib)		☐ Zeposia® (ozanimod)	
☐ Simponi® (golimumab)		☐ Other: _____	
Prescription Details			
☐ Loading	Dose: _____	Start Date: _____	
Route: ☐ SQ ☐ IV ☐ PO ☐	Frequency: _____	Quantity: _____	Refills: _____
☐ Maintenance	Dose: _____	Start Date: _____	
Route: ☐ SQ ☐ IV ☐ PO ☐	Frequency: _____	Quantity: _____	Refills: _____
IV pre-Meds			
(30-60min before infusion)			
☐ Acetaminophen _____ mg PO		☐ Methylprednisolone _____ mg ☐ PO ☐ IV	
☐ Diphenhydramine _____ mg ☐ PO ☐ IV		☐ Other: _____	
Clinical Information			
(Baseline Screening)			
☐ TB Test Completed	Date: _____	Result: ☐ Negative ☐ Positive	
☐ Hepatitis B Test Completed	Date: _____	Result: ☐ Negative ☐ Positive	
☐ Hepatitis Viral Load/Hep C Genotype	Date: _____	Result: _____	
Administration			
☐ Patient to self-administer	☐ Home Infusion Administration	☐ Office Administration	
Delivery			
☐ Ship to Patient	☐ Ship to Provider Office	☐ Other: _____	
By signing below, I certify that the above therapy is medically necessary and substitution is authorized unless noted otherwise.			
_____ Provider Signature		_____ Date	
		_____ Notes	

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