Golden HealthCare Specialty

GASTROENTEROLOGY

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Today's Date ________ Needs by ________ Ship to Patient at ☐ Home ☐ Office ☐ Other ________

PATIENT INFORMATION

Patient Name ________
Address ________
City ________ State ____ Zip ____
Phone ________ Alt Phone ________
Email ________
SS# ________ DOB ________
☐ Male ☐ Female Height ____ ft ____ in Weight ____ ☐ kg ☐ lb
☐ **SEND COPY OF PATIENT'S INSURANCE CARDS: FRONT AND BACK**

PRESCRIBER INFORMATION

Prescriber Name ________
DEA# ________ NPI# ________ License# ________
Address/Suite ________
City ________ State ____ Zip ____
Phone ________ Fax ________
Email ________
Contact Person ________
Best Contact via: ☐ Phone ☐ Fax ☐ Email ☐ Other ________

DIAGNOSIS/CLINICAL INFORMATION (PLEASE SEND A COPY OF ALL PERTINENT LABS AND CHART NOTES)

ICD-10 Diagnosis: ☐ **K50.90** Crohn's Disease ☐ **K50.90** Pediatric Crohn's Disease ☐ **K51.90** Ulcerative Colitis ☐ **K51.90** Pediatric Ulcerative Colitis ☐ **K58.0** IBS-D ☐ **Other ICD-10** ____ ________

Allergies: ________

Prior/Current Medication History: ☐ 5-ASA ☐ 6-Mercaptopurine ☐ Azathioprine ☐ Oral Corticosteroid ☐ Sulfasalazine ☐ Topical (Rectal) Corticosteroid ☐ Biologics ________ ☐ Other ________

Is there a presence of enterocutaneous/rectovaginal fistulas? ☐ No ☐ Yes

TB Test: ☐ No ☐ Yes Date: ________ Results: ________ (Please send lab results)

Please list prior tried medications:
Medication ________ Length of Treatment ________ Reason for Discontinuing ________
Medication ________ Length of Treatment ________ Reason for Discontinuing ________

PRESCRIPTION INFORMATION

MEDICATION & DOSAGES	DIRECTIONS	QTY	REFILLS
☐ **Cimzia®** *(certolizumab pegol)* ☐ 200mg PFS ☐ 200mg vial ☐ PFS Starter Kit 6 x200mg/ml	☐ **Starter Kit** 6 PFS or Vials: Inject 400mg subcutaneously at weeks 0, 2, and 4 ☐ **Maintenance**: Inject 400mg subcutaneously every 4 weeks ☐ *Enroll in CIMplicity*	1 Starter Kit 4 Week Supply	0 ____
☐ **Dificid®** *(fidaxomicin)* ☐ 200mg tablet	☐ **Take** 1 tablet by mouth twice a day for 10 days ☐ *Enroll in Merck Merck Patient Assistance*	20 Tablets	____
☐ **Entyvio®** *(vedolizumab)* ☐ 300mg vial ☐ *Enroll Entyvio Connect*	☐ **Load**: Infuse 300mg IV over 30 minutes at week 0, 2, and 6, then every 8 weeks thereafter ☐ **Maintenance**: Infuse 300mg IV over 30 minutes every 8 weeks	Loading Dose 8 Week Supply	0 ____
☐ **Humira® Citrate Free** ☐ *Enroll in Ambassador Program* ☐ Crohn's/UC Starter Package (3-80mg Pens) ☐ 40mg Pen ☐ 40mg PFS Pediatric 17kg to < 40kg ☐ 20mg PFS ☐ Pediatric Crohn's Disease Starter Pkg (2 ct) 80mg/0.8mL, 40mg/0.4mL in a single-use PFS Pediatric ≥ 40kg ☐ 40mg Pen ☐ 40mg PFS ☐ Pediatric Crohn's Disease Starter Pkg (3 c -use PFS	**Humira Citrate Free** ☐ **Starter**: Inject 160mg (two pens) subcutaneously on day 1, then 80mg (one pen) on day 15 ☐ **Maintenance**: Inject 40mg (one pen) subcutaneously every 2 weeks starting on day 29 **Humira** Pediatric 17kg to < 40kg ☐ **Load**: Inject 80mg (two pens) subcutaneously on day 1, then 40mg (one pen) on day 15 ☐ **Maintenance**: Inject 20mg (one pen) subcutaneously every other week Pediatric ≥ 40kg ☐ **Load**: Inject 160mg (two pens) subcutaneously on day 1, then inject 80mg (one pen) on day 15 ☐ **Maintenance**: Inject 40mg (one pen) subcutaneously every other week	Loading Dose 4 Week Supply	0 ____
☐ **Humira®** ☐ 40mg Pen ☐ 40mg PFS ☐ *Enroll in Ambassador Program*	☐ **Load**: Inject 160mg (four pens) subcutaneously on day 1, then 80mg (two pens) on day 15 ☐ **Maintenance**: Inject 40mg (one pen) subcutaneously every 2 weeks starting on day 29	Loading Dose 4 Week Supply	0 ____
☐ **Remicade®** *(infliximab)* ☐ 100mg vial ☐ *Enroll in Janssen CarePath*	☐ **Load**: Infuse ____ mg (____ mg/kg) at weeks 0, 2, and 6 ☐ **Maintenance**: Infuse ____ mg (____ mg/kg) every 8 weeks ☐ **Pediatric Load**: Infuse ____ mg (5mg/kg) at 0, 2, and 6 weeks, then every 8 weeks thereafter ☐ **Pediatric Maintenance**: Infuse ____ mg (5mg/kg) every 8 weeks	Loading Dose 8 Week Supply	0 ____
☐ **Simponi®** *(golimumab)* ☐ 100mg SmartJect ☐ 100mg PFS ☐ *Enroll in Janssen CarePath*	☐ **Load**: Inject 200mg (two-100mg injections) subcutaneously at week 0, then 100mg at week 2, then 100mg every 4 weeks thereafter ☐ **Maintenance**: Inject 100mg subcutaneously every 4 weeks	Loading Dose 4 Week Supply	0 ____
☐ **Stelara®** *(ustekinumab)* ☐ 90mg/ml PFS ☐ *Enroll in Janssen CarePath* Patient Weight (kg) ____ IV Loading Dose Administered on: ________	☐ **Load**: Infuse ____ mg IV initially at week 0 Weight of Patient / Recommended dosage / Vials ≤ 55 Kg / 260 mg / 2 >55 Kg to 85 Kg / 390 mg / 3 > 85 Kg / 520 mg / 4 ☐ **Maintenance**: 90mg subcutaneously 8 weeks after the initial intravenous dose, then every 8 weeks thereafter.	Loading Dose 1 syringe ___ Days Supply	0 ____
☐ **Xeljanz®** *(tofacitinib)* ☐ 10mg tab ☐ 5mg tab ☐ **Xeljanz XR®** *(tofacitinib)* ☐ 22mg tab ☐ 11mg tab ☐ *Enroll in XELSOURCE™*	**Induction:** ☐ **Take** one **Xeljanz** 10mg tablet by mouth twice daily ☐ **Take** one **Xeljanz XR** 22mg tablet by mouth once daily **Maintenance:** ☐ **Take** one **Xeljanz** 5mg tablet twice daily ☐ **Take** one **Xeljanz XR** tablet 11mg once daily	60 tab / 30 days 30 tab / 30 days 30 tab / 30 days 60 tab / 30 days	____
☐ **Xifaxan®** *(Rifaximin)* ☐ 200mg tab ☐ 550mg tab ☐ *Enroll in Patient Assistance Program*	**Hepatic Encephalopathy:** ☐ Take 1 tablet by mouth twice a day **Irritable Bowel Syndrome with Diarrhea**: ☐ Take 1 tablet by mouth 3 times a day for 14 days **Traveler's diarrhea**: ☐ Take 1 200mg tablet by mouth 3 times a day for 3 days	60 Tablets 42 Tablets 9 Tablets	____

Prescriber's Signature (*no stamps*) ________ ☐ **Dispense as Written** **Date** ________

By signing above, I authorize GOLDEN HEALTHCARE SPECIALTY PHARMACY and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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