



SPECIALTY PHARMACY

GASTROENTEROLOGY

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krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER _____

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contact Person	

PLEASE FAX COPY OF: ☐ PRESCRIPTION CARD FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis Code: ☐ K50.90 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other: _____

Drug Allergies: _____

History: • Has the Patient been treated previously for this condition? ☐ Yes ☐ No

<input type="checkbox"/> NSAIDS	Duration _____	<input type="checkbox"/> Sulfasalazine	Duration _____	<input type="checkbox"/> Corticosteroid	Duration _____
<input type="checkbox"/> MTX	Duration _____	<input type="checkbox"/> 5-ASA (5-Aminosalicylates)	Duration _____	<input type="checkbox"/> 6-MP (6-Mercaptopurine)	Duration _____
<input type="checkbox"/> Biologics	Duration _____	<input type="checkbox"/> Azathioprine	Duration _____	<input type="checkbox"/> Other	Duration _____

• Is the patient currently on any therapy? ☐ Yes ☐ No List Meds: _____• Will patient stop taking Meds before starting the new med? ☐ Yes ☐ No • How long will the patient wait before starting the new med? _____

• Other meds patient is on? _____

• Has patient received PPD (skin test)? ☐ Yes ☐ No • Results: _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Cimzia*	<input type="checkbox"/> 200x2 Prefilled Syringe <input type="checkbox"/> 200x2 LYO Powder	<input type="checkbox"/> Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 <input type="checkbox"/> Inject 400mg subcutaneously once every 4 weeks	1 Kit 4 week supply	none _____
<input type="checkbox"/> Creon*	<input type="checkbox"/> 3,000 <input type="checkbox"/> 6,000 <input type="checkbox"/> 12,000 <input type="checkbox"/> 24,000 <input type="checkbox"/> 36,000	Take ____ capsules three times daily with meals and ____ capsules with ____ snacks daily for a total of ____ capsules a day	_____	_____
<input type="checkbox"/> Dificid*	200mg Tablet	1 tablet orally twice a day with or without food for 10 days.	20	_____
<input type="checkbox"/> Entyvio*	300mg vial	<input type="checkbox"/> Loading Dose: Infuse 300mg IV over 30 minutes at week 0, week 2 and week 6 <input type="checkbox"/> Maintenance: Infuse 300mg IV over 30 minutes every 8 weeks	3	none _____
<input type="checkbox"/> Humira*	<input type="checkbox"/> Crohn's/UC Starter Package (6 - 40mg Prefilled Pens) <input type="checkbox"/> 40mg Prefilled Pen <input type="checkbox"/> 40mg Prefilled Syringe	160mg given as <input type="checkbox"/> Four 40mg SubQ day 1 OR <input type="checkbox"/> Two 40mg SubQ days 1 & 2 then Week 2 inject 80mg (Two 40mg injections) subcutaneously on day 15 <input type="checkbox"/> Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	none _____
<input type="checkbox"/> Remicade* Wt: _____	100mg Vial	Loading Dose: <input type="checkbox"/> Infuse _____mg IV on week 0, week 2, week 6, then Maintenance: <input type="checkbox"/> Infuse _____mg IV every _____ weeks for _____ infusions	Loading dose 4 week supply	none _____
<input type="checkbox"/> Simponi* UC	<input type="checkbox"/> 100mg SmartJect <input type="checkbox"/> 100mg Prefilled Syringe	<input type="checkbox"/> Inject 200mg subcutaneously at week 0, then 100mg at week 2, 100mg every 4 weeks <input type="checkbox"/> Inject 100mg subcutaneously once every 4 weeks	Loading dose 4 week supply	none _____
<input type="checkbox"/> Epipen*	0.3mg	Inject 1 pen intramuscularly once, may repeat if necessary. Call 911 if needed.	2	_____
<input type="checkbox"/> Stelara*	90mg Prefilled Syringe	Crohn's Maintenance: Inject 90 mg subcutaneously every 8 weeks.	8 week supply	_____
<input type="checkbox"/> Xifaxan*	550mg Tablets	<input type="checkbox"/> 1 tablet by mouth twice a day <input type="checkbox"/> 1 tablet by mouth three times a day	1 month supply 2 week supply	_____
<input type="checkbox"/> Other	_____	_____	_____	_____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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