GASTROENTEROLOGY

Garden Grove, CA toll free 800.228.3643 toll free fax 866.539.1092
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

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

PATIENT INFO

Patient Name
Address
City, State, Zip
Main Phone Alternate Phone
Social Security #
Date of Birth ❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name
DEA # NPI # License #
Address
City, State, Zip
Phone Fax
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

❑ NSAIDS	Duration_____	❑ Sulfasalazine	Duration_____	❑ Corticosteroid	Duration_____
❑ MTX	Duration_____	❑ 5-ASA (5-Aminosalicylates)	Duration_____	❑ 6-MP (6-Mercaptopurine)	Duration_____
❑ Biologics	Duration_____	❑ Azathioprine	Duration_____	❑ 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
❑ Cimzia®	❑ 200x2 Prefilled Syringe ❑ 200x2 LYO Powder	❑ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 ❑ Inject 400mg subcutaneously once every 4 weeks	1 Kit 4 week supply	none _____
❑ Creon®	❑ 3,000 ❑ 6,000 ❑ 12,000 ❑ 24,000 ❑ 36,000	Take ___ capsules three times daily with meals and ___ capsules with ___ snacks daily for a total of ___ capsules a day	_____	_____
❑ Dificid®	200mg Tablet	1 tablet orally twice a day with or without food for 10 days.	20	_____
❑ Entyvio®	300mg vial	❑ Loading Dose: Infuse 300mg IV over 30 minutes at week 0, week 2 and week 6 ❑ Maintenance: Infuse 300mg IV over 30 minutes every 8 weeks	3 _____	none _____
❑ Humira®	❑ Crohn's/UC Starter Package (6 - 40mg Prefilled Pens) ❑ 40mg Prefilled Pen ❑ 40mg Prefilled Syringe	160mg given as ❑ Four 40mg SubQ day 1 OR ❑ Two 40mg SubQ days 1 & 2 then Week 2 inject 80mg (Two 40mg injections) subcutaneously on day 15 ❑ Week 4+: Inject 40mg subcutaneously every other week _____	Loading Dose 4 week supply	none _____
❑ Remicade® Wt: _____	100mg Vial	Loading Dose: ❑ Infuse _____mg IV on week 0, week 2, week 6, then Maintenance: ❑ Infuse _____mg IV every _____ weeks for _____ infusions	Loading dose 4 week supply	none _____
❑ Simponi® UC	❑ 100mg SmartJect ❑ 100mg Prefilled Syringe	❑ Inject 200mg subcutaneously at week 0, then 100mg at week 2, 100mg every 4 weeks ❑ Inject 100mg subcutaneously once every 4 weeks	Loading dose 4 week supply	none _____
❑ Epipen®	0.3mg	Inject 1 pen intramuscularly once, may repeat if necessary. Call 911 if needed.	2	_____
❑ Stelara®	90mg Prefilled Syringe	Crohn's Maintenance: Inject 90 mg subcutaneously every 8 weeks.	8 week supply	_____
❑ Xifaxan®	550mg Tablets	❑ 1 tablet by mouth twice a day ❑ 1 tablet by mouth three times a day	1 month supply 2 week supply	_____ _____
❑ 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