GASTROENTEROLOGY ENROLLMENT FORM

FocusRx
Positive Patient Outcomes

FAX REFERRAL TO: 1-888-801-0404
PHONE: 1-888-570-9077

Date: _____ • Ship to: ☐ Patient ☐ Office

Needs by Date: _____

PATIENT INFORMATION
(Complete the following *or send patient demographic sheet)*

Name: _____

Address _____

City, State, Zip: _____

Cell Phone: _____

Home Phone: _____

SS#: _____

Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

DEA #: _____ NPI #: _____

Group/Hospital: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax _____

Contact Person: _____

INSURANCE INFORMATION

Primary Insurance/Prescription Card:
PLEASE FAX COPY OF INS CARD (front and back if available)

Secondary Insurance/Prescription Card:
PLEASE FAX COPY OF INS CARD (front and back if available)

Crohns Disease Clinical Info
ICD 10 Code

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Previously Tried Medications:

☐ Methotrexate ☐ Nsaids
☐ Corticosteroid ☐ Azathioprene
☐ Sulfasalazine ☐ 6-MP
☐ Biologics:_____

Does pt. have active infection? ☐ No

Has pt. been diagnosed with Lymphoma or Heart failure? ☐ No

PATIENT DEMOGRAPHICS:

Weight: _____Kg or _____ Lbs

Height: _____inches BSA:_____ m^2

Allergies:

Other relevant conditions:

PRESCRIPTION INFORMATION

MEDICATION	DOSE	FREQUENCY/DIRECTIONS FOR USE	QUANTITY	REFILLS
☐ Humira®	☐ 40mg starter pack ☐ 40 MG Syringe ☐ 40 MG Pen ☐ 20 MG Syringe	☐ Induction Dose: Inject 160mg sc (4 pens) on day 1, then 80mg (2 pens) on day 15, then maintenance dosing ☐ Maintenance Dose: Inject 40mg sc (one pen) every other week. ☐ Other: _____		
☐ Cimzia®	☐ Cimzia Starter Kit ☐ 200mg/1 mL PFS ☐ 200mg vial	☐ Induction Dose: Inject 400mg sc (2 vials) on day 1, and at weeks 2 and 4. ☐ Maintenance Dose: Inject subcutaneously 400mg (2 vials) every 4 weeks.		
☐ Remicade®	☐ 100 mg vials	☐ Induction Dose: IV at 5mg/kg (Dose= _____mg) at 0, 2, and 6 weeks. ☐ Maintenance Dose: IV at 5mg/kg (Dose= _____mg) every 8 weeks. ☐ Other: _____		
☐ Stelara®	☐ 45 MG Syringe ☐ 90 MG Syringe	For patients <100 kg, administer: ☐ Induction dose of 45mg at week 0 and week 4 followed by: ☐ Maintenance dose of 45mg every 12 weeks For patients >100 kg, administer ☐ Initial dose of 90mg at week 0 and week 4 followed by: ☐ Maintenance dose of 90mg every 12 weeks		
☐ Entyvio®	☐ 300 mg vials	☐ Initial dose of 300mg infused over 30 minutes week 0, 2, and 6, then every 8 weeks ☐ Maintenance dose of 300mg infused over 30 minutes every 8 weeks		
☐ Simponi®	☐ 100mg pfs ☐ 50mg pfs ☐ 100mg smartject ☐ 50mg smartject	☐ Induction dose 200mg week 0, 100mg week 2, then 100mg every 4 weeks ☐ Maintenance dose 100mg every 4 weeks		
☐ Other:				

☒ *I authorize Focus Rx staff or its representatives to act as an agent of prescriber to execute any prior authorization or appeal on my behalf.*

_____
Prescriber Signature (Date)