



SPECIALTY PHARMACY

GASTROENTEROLOGY

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192

krogerspecialtypharmacy.com

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	<input type="checkbox"/> Male <input type="checkbox"/> 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

<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-Aminosaliclates)	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 by mouth 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 Pens) <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg PFS	Inject 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"/> Humira* Citrate Free	<input type="checkbox"/> Crohn's/UC Starter Package (3 - 80mg Pens) <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg PFS	Inject 160mg given as <input type="checkbox"/> Two 80mg SubQ Day 1 OR <input type="checkbox"/> One 80mg SubQ days 1 & 2 then week 2 inject 80mg 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	Inject 90 mg subcutaneously every 8 weeks Infusion Dose Date: _____	8 week supply	_____
<input type="checkbox"/> Xeljanz*	<input type="checkbox"/> 10mg <input type="checkbox"/> 5mg	1 tablet by mouth twice a day	60	_____
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 its 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

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. 04880 09-23-2018 NOLA