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 INFORMATION	PRESCRIBER INFORMATION
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 ❑ Male ❑ Female	Contact Person

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

CLINICAL INFORMATION

Diagnosis: ❑ K50.90 Crohn's Disease ❑ K51.90 Ulcerative Colitis ❑ Other: Dx code _______________ Condition ______________________________

Drug Allergies: ______________________________ Weight: _______________ ❑ kg ❑ lb

Prior/Current Medication History:

❑ Sulfasalazine ❑ Oral Corticosteroid ❑ Azathioprine ❑ 6-Mercaptopurine ❑ Topical (Rectal) Corticosteroid ❑ 5-ASA

❑ Biologics: ______________________________ ❑ Other: ______________________________

Presence of enterocutaneous/rectovaginal fistulas? ❑ No ❑ Yes

Does patient have a latex allergy? ❑ No ❑ Yes **TB Test:** ❑ No ❑ Yes Date: _______________ Results: ______________________________ (Please send lab results)

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Cimzia®	❑ 200mg x2 PFS ❑ 200mg x2 Vial	❑ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2, and 4 ❑ Maintenance: Inject 400mg subcutaneously every 4 weeks	1 Starter Kit (PFS)/6 Vials 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	Take 1 tablet by mouth twice a day for 10 days	20 Tablets	__________
❑ Entyvio®	300mg Vial	❑ 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	None __________
❑ Humira® Citrate Free	❑ Crohn's/UC Starter Package (3-80mg Pens) 40mg ❑ Pen ❑ PFS	Load: Inject 160mg subcutaneously as ❑ two-80mg injections on day 1 **or** ❑ one-80mg injection on day 1 and then day 2, then inject 80mg on day 15, then inject 40mg every other week thereafter Maintenance: Inject 40mg subcutaneously every other week	Loading Dose 4 Week Supply	None __________
❑ Humira®	❑ Crohn's/UC Starter Package (6-40mg Pens) 40mg ❑ Pen ❑ PFS	Load: Inject 160mg subcutaneously as ❑ four-40mg injections on day 1 **or** ❑ two-40mg injections on day 1 and then day 2, then inject 80mg (two-40mg injections) on day 15, then inject 40mg every other week thereafter Maintenance: Inject 40mg subcutaneously every other week	Loading Dose 4 Week Supply	None __________
❑ Remicade®	100mg Vial	❑ Load: Infuse ________ mg (________ mg/kg) at weeks 0, 2, and 6 ❑ Maintenance: Infuse ________ mg (________ mg/kg) every 8 weeks	Loading Dose 8 Week Supply	None __________
❑ Simponi®	100mg ❑ SmartJect ❑ PFS	❑ 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	None __________
❑ Stelara®	90mg PFS	Inject 90mg subcutaneously every 8 weeks IV Loading Dose Administered on: ________	8 Week Supply	__________
❑ Xeljanz®	❑ 10mg Tablet ❑ 5mg Tablet ❑ 22mgXR Tablet ❑ 11mg XR Tablet	Take 1 tablet by mouth twice a day Take 1 tablet by mouth daily	60 Tablets 30 Tablets	__________ __________
❑ Xifaxan®	550mg Tablet	*Hepatic Encephalopathy:* ❑ Take 1 tablet by mouth twice a day *Irritable Bowel Syndrome with Diarrhea:* ❑ Take 1 tablet by mouth three times a day for 14 days	60 Tablets 42 Tablets	__________ __________
❑ 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

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