Gastroenterology Enrollment Form

25329 Budde Road, Suite #104
Spring, TX 77380
Phone: 832-713-6119 . Fax: 281-809-6917

PATIENT INFORMATION

Name: _____ DOB: _____ Gender: □ M □ F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ Email: _____

Language : □ English □ Spanish □ Other: _____ Height: _____ Weight: _____

STATEMENT OF MEDICAL NECESSITY

DIAGNOSIS (ICD-10 CODES): □ **K50.90** Crohn's Disease □ **K51.80** Ulcerative Colitis □ **K58.0** Irritable Bowel Syndrome With Diarrhea (IBS-D)

Other: _____ Date:_____ Allergies: _____ □ **NKDA**

Prior Failed Treatments:

Biologics: □ Humira □ Enbrel □ Remicade □ Other: _____

□ 5– ASA □ Azathioprine □ Corticosteroids

□ Methotrexate □ 6-MP □ Sulfasalazine □ Other: _____

Patient Evaluation:

□ Crohn's Severity: □ Moderate □ Severe

□ TB Test □ Positive □ Negative

□ Hep B ruled out or treatment started? □ Yes □ No

PRESCRIPTION INFORMATION

Medication	Dose & Strength	Directions	Qty	Refills
□ **AVSOLA®**	□ 100mg Vial	□ **Induction Dose:** IV at 5 mg/kg at week 0, week 2, week 6 and every 8 weeks thereafter. □ **Maintenance Dose:** IV at 5 mg/kg every 8 weeks. □ Others:	.....	.....
□ **ENTYVIO®**	□ 300mg Vial	□ Infused 300mg IV over 30min at week 0, week 2, week 6 then every 8 weeks. □ Others:	.....	.....
□ **HUMIRA®**	□ Crohn's Starter Pack □ 40mg Injectable Pen □ 40mg Prefilled Syringe	□ **Induction Dose:** Inject Subq 160mg on day 1, then 80mg on day 15, then maintenance. □ **Maintenance Dose:** Inject subcutaneously 40mg every other week. □ **Maintenance Dose:** Inject subcutaneously 40mg every other week.	.....	.....
□ **HUMIRA CF®** (Citrate-free)	□ Humira Starter Pack CD/UC/HS □ 40mg Pen □ 40mg Prefilled Syringe	**Weight (>88lbs)** □ **Induction Dose:** Inject subcutaneously 160mg on day 1, then 80mg on day 15, then maintenance. □ **Maintenance Dose:** Inject subcutaneously 40mg every other week.	.....	.....
□ **INFLECTRA®**	□ 100mg Vial	□ **Induction Dose:** IV at 5 mg/kg at week 0, week 2, week 6 and every 8 weeks thereafter. □ **Maintenance Dose:** IV at 5 mg/kg every 8 weeks. □ Others:	.....	.....
□ **INJECTAFER®**	□ 15mg/kg □ 750mg	□ **15mg/kg IV** - Give 2 doses at least 7 days apart not to exceed 1500mg. if patient weighing less than 50kg (110lbs) □ **750mg IV** - Give 2 doses at least 7 days apart not to exceed 1500mg. if patient weighing 50kg (110lbs) or greater □ Others:	.....	.....
□ **REMICADE®**	□ 100mg Vial	□ **Induction Dose:** IV at 5 mg/kg at week 0, week 2, week 6 and every 8 weeks thereafter. □ **Maintenance Dose:** IV at 5 mg/kg every 8 weeks. □ Others:	.....	.....
□ **RENFLEXIS®**	□ 100mg Vial	□ **Induction Dose:** IV at 5 mg/kg at week 0, week 2, week 6 and every 8 weeks thereafter. □ **Maintenance Dose:** IV at 5 mg/kg every 8 weeks. □ Others:	.....	.....
□ **SIMPONI ARIA®**	□ 50mg/4ml	□ **Induction Dose:** Infused 2mg/kg at week 0, 4 then every 8 weeks. □ **Maintenance Dose:** Infused 2mg/kg every 8 weeks. □ Others:	.....	.....
□ **STELARA®**	□ 130mg/26ml Vial □ 90mg/ml Syringe	□ **Induction Dose:** Infuse _____ mg x dose. (□ 55kg or less—260mg; □ 55-85kg—390mg; □ 85kg or more—520mg) □ **Maintenance Dose:** 90mg Subq 8 weeks after initial and then every 8 weeks. □ Others:	.....	.....
□ **ZINPLAVA®**	□ 25mg/ml	□ The recommended dose is a single dose of 10 mg/kg administered as an intravenous infusion over 60 minutes . □ Others:	.....	.....

Prescriber's Signature: _____ □ **DAW (Dispense As Written) Date:** _____

Prescriber's Name: _____ **Phone:** _____ **Fax:** _____

Prescriber's Address: _____ **City:** _____ **State:** _____ **Zip:** _____

NPI: _____ **DEA:** _____ **Tax I.D:** _____ **Office Contact:** _____