

GREATER PLACER SPECIALTY PHARMACY

3133 PROFESSIONAL DRIVE #17 AUBURN, CA 95603
 PHONE: 530-885-8582 | FAX: 530-885-8593 OR 888-696-6055 | WWW.GPRX1.COM

Date: _____ **GASTROENTEROLOGY/CROHN'S/ULCERATIVE COLITIS PRESCRIPTION FORM**

PATIENT INFORMATION

| | | |
|--|---|--|
| Patient Name: _____ Address: _____ City, State, Zip: _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: _____ SSN: _____ Phone: _____ | Need by Date: _____ Ship to: <input type="checkbox"/> Patient Home <input type="checkbox"/> Other: _____ |
|--|---|--|

PRESCRIBER INFORMATION

| | | |
|-------------------------|-----------------------|------------|
| Prescriber Name: _____ | DEA: _____ | NPI: _____ |
| Address: _____ | Phone: _____ | Fax: _____ |
| City, State, Zip: _____ | Contact Person: _____ | |

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: 555.9 Crohn's Disease 556.9 Ulcerative Colitis 009.2 Traveler Diarrhea 572.2 Hepatic Encephalopathy _____

Date of Diagnosis/ Years with disease: _____ Try and Fail medications: _____ ALT: _____ HCV RNA: _____

Weight: _____ lbs / kg Height: _____ Allergies: _____ AST: _____ TB Test: _____

PRESCRIPTION INFORMATION

INITIAL PRESCRIPTION PREVIOUSLY DISPENSED **MEDICATIONS**

| MEDICATION | STRENGTH | DIRECTION | QTY | REFILLS |
|------------------------------------|--|--|-----|---------|
| <input type="checkbox"/> Cimzia® | <input type="checkbox"/> Starter Package (200mg) <input type="checkbox"/> 200mg | <input type="checkbox"/> Initial Dose: Inject 400mg SQ at week 0,2,4 <input type="checkbox"/> Maintenance Dose: Inject 400 SQ every 4 weeks | | |
| <input type="checkbox"/> Humira® | <input type="checkbox"/> 40mg/0.4ml PFS (2 doses) | <input type="checkbox"/> Initial Dose: Inject 160mg SQ on day 1, then 80mg on day 15 <input type="checkbox"/> Maintenance: Inject 40mg SQ every other week | | |
| <input type="checkbox"/> Remicade® | <input type="checkbox"/> 100mg/20ml vial | <input type="checkbox"/> Initial: Inject 5mg/kg IV at week 0,2,and 6 <input type="checkbox"/> Maintenance: Inject 5mg/kg IV every 8 weeks thereafter | | |
| <input type="checkbox"/> Simponi® | <input type="checkbox"/> 100 mg Smartject <input type="checkbox"/> 100mg PFS | <input type="checkbox"/> Initial: Inject 200mg SQ at week 0, then 100mg at week 2 <input type="checkbox"/> Maintenance: Inject 100mg SQ every 4 weeks, starting week 6 <input type="checkbox"/> Other: | | |
| <input type="checkbox"/> Xifaxan® | <input type="checkbox"/> 200mg <input type="checkbox"/> 550mg | <input type="checkbox"/> Take _____ tablets _____ times per day | | |

Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Greater Placer Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ **Date:** _____ **Do not substitute**

Patient Support Programs:

By signing below, I authorize Greater Placer Pharmacy to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ **Date:** _____

Important Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that is protected under federal and state laws. If you are not the intended recipient, please notify the sender and destroy this document immediately.