GI ENROLLMENT FORM

GREENHILL PLUS+
Specialty Pharmacy Solution
Connection • Care • Community

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Patient Name _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ SSN _____ Gender ○ M ○ F
Weight _____ kg/lbs Height _____ cm/in
Language Preference: ○ English ○ Spanish ○ Other _____
Caregiver Name _____ Relation _____
Local Pharmacy _____ Phone _____
Insurance Plan _____ Plan ID _____

Please fax a copy of front and back of the insurance card(s)

Prescriber Information & Shipping Information

Prescriber's Name _____
NPI _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Contact _____
Phone _____ Alternate Phone _____
Fax _____
Email _____
If shipping to prescriber ○ First Fill ○ Always ○ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Crohn's Disease:
○ K50.0 (Crohn's Disease of the **Small** Intestine)
○ K50.8 (Crohn's Disease of **Both** Intestines)
○ K50.1 (Crohn's Disease of the **Large** Intestine)
○ K50.9 (Crohn's Disease, unspecified)

Ulcerative Colitis:
○ K51.0 (Ulcerative Pancolitis)
○ K51.3 (Ulcerative Rectosigmoiditis)
○ K51.8(Other Ulcerative Colitis)
○ K51.2 (Ulcerative Pancolitis)
○ K51.5 (Left Sided Colitis)
○ K51.9 (Ulcerative Colitis, unspecified)

Other: ○ _____

Diagnosis Date: _____ TB Test: ○ Yes ○ No Neg. Test Date: _____

Prior Therapy ○ Yes ○ No | Reason for Discontinuation of Therapy | Approximate Start Date | Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ○ NKDA ○ Other: _____

Prescription Information

Drugs	Direction	Quantity	Refills
Cimzia® (certolizumab) ○Vials ○PFS	○ Inject 400 mg subcut at week 0, 2 and 4 ○ Inject 400 mg subcut every 4 weeks	○6x200 mg/ml ○2x100 mg/ml	
Humira® (adalimumab) Adults ○Pens ○PFS	○ Inject 160 mg subcut on day 1 then 80 mg on day 15 ○ _____ ○ Inject 40 mg subcut on day 29 and every other week thereafter	○6x40 mg/0.8ml ○2x40 mg/0.8ml	
Humira® (adalimumab) Pediatrics ≥ 6 years ○Pens ○PFS	○ Inject 80 mg subcut day 1, then 40 mg on day 15 (17 to <40 kg) ○ Inject 160 mg subcut day 1, then 80 mg on day 15 (≥40 kg) ○ _____ ○ Inject 20 mg subcut on day 29 and every other week thereafter (17 to <40 kg) ○ Inject 40 mg subcut on day 29 and every other week thereafter (≥40 kg)	○3x40 mg/0.8ml ○6x40 mg/0.8ml ○2x20 mg/0.4ml ○2x40 mg/0.8ml	
Patient eligible for self-administration: ○ Yes ○ No			
Entyvio® (adalimumab)	○ Infuse 300 mg IV over 30 minutes at 0, 2, and 6 weeks, then every 8 weeks there after		
Xifaxan® (rifaximin)	○ Take one tablet by mouth twice daily ○ Take one tablet by mouth three times daily for 14 days	 ○ 42	

Drugs	Direction	Quantity	Refills
Simponi® (golimumab) ○SmartJect® Autoinjector ○PFS	○Inject 200 mg subcut at week 0, then 100 mg at week 2 ○Inject 100 mg subcut every 4 weeks	○3x100 mg/ml ○1x100 mg/ml	
Stelara® (ustekinumab) ○PFS ○Pens	○Inject 90 mg subcut 8 weeks following initial intravenous dose, then every 8 weeks thereafter	○1x90 mg/ml	
Patient eligible for self-administration: ○ Yes ○ No			
Humira® ○ Pediatric Crohn's Disease Starter Package (3 count) 40mg/0.8 mL in a single-use prefilled glass syringe	17kg (37 lbs) to < 40kg (88lbs): ○ Load: Day 1: Inject 80mg (two 40mg injections in one day), then on Day 15 (two weeks later) give 40mg injection ○ Maintenance begins two weeks later: Day 29: Inject 20mg every other week	○ Loading Dose ○ 4 week supply	
○ Pediatric Crohn's Disease Starter Package (6 count) 40mg/0.8 mL in a single-use prefilled glass syringe	≥ 40kg (88lbs): ○ Load: Day 1: Inject 160mg given as o four 40mg injections in one day OR o two 40mg injections per day for two days in a row, then on Day 15 (two weeks later) give 80mg (two 40mg injections) in one day ○ Maintenance begins two weeks later: Day 29: Inject 40mg every other week	○ Loading Dose ○ 4 week supply	
○ Crohn's Starter Package (6 count) 40mg single-use pen ○ 20 mg Pre Filled Syringe ○ 40 mg Pre Filled Syringe ○ 40 mg Pre Filled Pen			

Injection Training Provided by: ○Physician's Office ○Pharmacy ○Other: _____
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Ship to: ○ ***Patient*** ○ ***Office*** ○ ***Other*** _____ ***Date*** _____ ***Needs by Date*** _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: _____ PRODUCT SUBSTITUTION PERMITTED _____ DISPENSE AS WRITTEN ***Date:*** _____

Supervising Physician / Supervising Physician Signature: _____

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NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH CROHNS & ULCERATIVE COLITIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days. ***Please forward and updates to us you receive from the insurance company regarding approvals or denials.***

REQUIRED INFORMATION:

- ○ Patient Name
- ○ Patient Demographics (Address, Phone Number, DOB, etc.)
- ○ Medication list and allergies
- ○ Insurance information with prescription insurance. Please include a copy of card.
  If only medical insurance card is provided, please include local pharmacy information.
- ○ MD Name/NPI/Office Contact/Phone Number
- ○ Drug indicated with refills
- ○ MD signature and date on referral form
- ○ Recent TB test results and date
- ○ Previous treatment
- ○ Symptoms
- ○ Clinical notes

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