

GI ENROLLMENT FORM

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) K50.1 (Crohn's Disease of the **Large** Intestine)
 K50.8 (Crohn's Disease of **Both** Intestines) K50.9 (Crohn's Disease, unspecified)
 Ulcerative Colitis: K51.0 (Ulcerative Pancolitis) K51.2 (Ulcerative Pancolitis)
 K51.3 (Ulcerative Rectosigmoiditis) K51.5 (Left Sided Colitis)
 K51.8 (Other Ulcerative 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	Directions	Quantity	Refills	Drugs	Directions	Quantity	Refills
Cimzia® (certolizumab) <input type="radio"/> Vials <input type="radio"/> PFS	<input type="radio"/> Inject 400 mg subcut at week 0, 2 and 4 <input type="radio"/> Inject 400 mg subcut every 4 weeks	<input type="radio"/> 6x200 mg/ml <input type="radio"/> 2x100 mg/ml		Simponi® (golimumab) <input type="radio"/> SmartJect® Autoinjector <input type="radio"/> PFS	<input type="radio"/> Inject 200 mg subcut at week 0, then 100 mg at week 2 <input type="radio"/> Inject 100 mg subcut every 4 weeks	<input type="radio"/> 3x100 mg/ml <input type="radio"/> 1x100 mg/ml	
Humira® (adalimumab) Adults <input type="radio"/> Pens <input type="radio"/> PFS	<input type="radio"/> Inject 160 mg subcut on day 1 then 80 mg on day 15 <input type="radio"/> _____ <input type="radio"/> Inject 40 mg subcut on day 29 and every other week thereafter	<input type="radio"/> 6x40 mg/0.8ml <input type="radio"/> 2x40 mg/0.8ml		Stelara® (ustekinumab) <input type="radio"/> PFS <input type="radio"/> Pens Patient eligible for self-administration: <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Inject 90 mg subcut 8 weeks following initial intravenous dose, then every 8 weeks thereafter	<input type="radio"/> 1x90 mg/ml	
Humira® (adalimumab) Pediatrics ≥ 6 years <input type="radio"/> Pens <input type="radio"/> PFS	<input type="radio"/> Inject 80 mg subcut day 1, then 40 mg on day 15 (17 to <40 kg) <input type="radio"/> Inject 160 mg subcut day 1, then 80 mg on day 15 (≥40 kg) <input type="radio"/> _____ <input type="radio"/> Inject 20 mg subcut on day 29 and every other week thereafter (17 to <40 kg) <input type="radio"/> Inject 40 mg subcut on day 29 and every other week thereafter (≥40 kg)	<input type="radio"/> 3x40 mg/0.8ml <input type="radio"/> 6x40 mg/0.8ml <input type="radio"/> 2x20 mg/0.4ml <input type="radio"/> 2x40 mg/0.8ml		Humira® <input type="radio"/> Pediatric Crohn's Disease Starter Package (3 count) 40mg/0.8 mL in a single-use, pre-filled glass syringe. <input type="radio"/> Pediatric Crohn's Disease Starter Package (6 count) 40mg/0.8 mL in a single-use, pre-filled glass syringe. <input type="radio"/> Crohn's Starter Package (6 count) 40mg single-use pen. <input type="radio"/> 20 mg Pre-Filled Syringe <input type="radio"/> 40 mg Pre-Filled Syringe <input type="radio"/> 40 mg Pre-Filled Pen	17kg (37 lbs) to < 40kg (88lbs): <input type="radio"/> Load: Day 1: Inject 80mg (two 40mg injections in one day), then on Day 15 (two weeks later) give 40mg injection <input type="radio"/> Maintenance begins two weeks later: Day 29: Inject 20mg every other week ≥ 40kg (88lbs): <input type="radio"/> Load: Day 1: Inject 160mg given as a four 40mg injections in one day OR a 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 <input type="radio"/> Maintenance begins two weeks later: Day 29: Inject 40mg every other week	<input type="radio"/> Loading Dose <input type="radio"/> 4 week supply <input type="radio"/> Loading Dose <input type="radio"/> 4 week supply	
Entyvio® (adalimumab)	<input type="radio"/> Infuse 300 mg IV over 30 minutes at 0, 2, and 6 weeks, then every 8 weeks thereafter						
Remicade® (janssen)	<input type="radio"/> Initiation Dose - Infuse 5mg/kg at weeks zero, two, six. <input type="radio"/> Maintenance Dose - Infuse 5mg/kg every eight weeks.	<input type="radio"/> 100mg/20ml Vial					
Xifaxan® (rifaximin)	<input type="radio"/> Take one tablet by mouth twice daily <input type="radio"/> Take one tablet by mouth three times daily for 14 days	<input type="radio"/> 42					

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: _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

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

GREENHILL PHARMACY (MARKET STREET)

824 N Market St., Wilmington, DE 19801

Physician Line: 302-516-7480 | Patient Line: 302-516-7507

Fax: 302-513-9396

GREENHILL PHARMACY (FOURTH STREET)

2511 W. 4th St. Suite F, Wilmington, DE 19805

Physician Line: 302-691-7833 | Patient Line: 302-660-8847

Fax: 302-502-3885