PREMIER PHARMACY SERVICES

Phone: 800-540-4700
Fax: 800-540-3400

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

GASTROENTEROLOGY RX ORDER FORM

_____

SHIP TO: ☐ Patient ☐ Physician

All supplies, including syringes, will be dispensed if needed.

PATIENT INFORMATION

Date: _____ DOB: _____ SS#_____

Patient's First Name: _____ Patient's Last Name: _____

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

Best Phone: _____ Alternate Phone: _____

Height: _____ Weight: _____ Emergency Contact: _____ Allergies: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Primary Insurance: _____ Phone: _____

Policy #: _____ Group #: _____

CLINICAL

Gender: ☐ M ☐ F

HT:_____

WT: _____

BSA: _____

DIAGNOSIS:

- ☐ Crohn's Disease K50.90
- ☐ Hepatic Encephalopathy K72.9
- ☐ Irritable Bowel Syndrome w/ Diarrhea K58.0
- ☐ Hepatitis B18.1
- ☐ Traveler's Diarrhea A09
- ☐ Ulcerative Colitis K51.90
- ☐ _____

PRESCRIPTIONS

				Qty.	Refills
HBV	☐ BARACLUDE ☐ VEMLIDY	☐ 0.5mg ☐ 1.0mg ☐ 25mg	☐ Take 1 tablet by mouth once daily ☐ _____		
HEPATIC	☐ XIFAXAN	☐ 200mg ☐ 550mg Prior Drugs Tried & Failed ☐ Lactulose ☐ Neomycin ☐ Other: _____ Dates: _____	☐ Traveler's Diarrhea: 200mg po tid x3 days ☐ Hepatic Encephalopathy: 550mg po bid ☐ IBS with diarrhea: 550mg po tid x14 days ☐ Other: _____		
CROHN'S DISEASE/ULCERATIVE COLITIS	☐ CIMZIA	☐ Starter kit 200mg ☐ 200mg/ml PFS	☐ **Initial dose:** inject 400mg SQ once weekly at week 0, 2, and 4 ☐ **Maintenance:** inject 400mg SQ every 4 weeks		
	☐ ENTYVIO	☐ 300mg vial	☐ **Initial dose:** infuse 1 vial (300mg) intravenously at week 0, 2, and week 6 ☐ **Maintenance:** infuse 1 vial (300mg) intravenously every 8 weeks		
	☐ HUMIRA	☐ Crohn's Disease /UC Starter Pack (6 x 40mg Pens) ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml PFS	☐ **Initial dose:** inject 160mg SQ on day 1, then 80mg on day 15 ☐ **Maintenance:** inject 40mg SQ every other week starting day 29		
	☐ REMICADE	100mg/20ml Vial	☐ **Initial dose**: infuse 5mg/kg IV at weeks 0, 2, and 6 ☐ **Maintenance:** infuse 5mg/kg IV every 8 weeks thereafter		
	☐ SIMPONI	☐ 100mg/ml Autoinjector ☐ 100mg/ml Prefilled Syringe	☐ **Initial dose:** inject 200mg SQ at week 0, then 100mg at week 2 ☐ **Maintenance:** inject 100mg SQ every 4 weeks, starting week 6		
	☐ STELARA	☐ 130mg/25ml SDV ☐ 90mg/ml PFS	☐ **Initial dose:** ☐ </= 55kg: 260mg (2 vials) IV as a single dose ☐ > 55kg to 85kg: 390mg (3 vials) IV as a single dose ☐ > 85kg: 520mg (4 vials) IV as a single dose ☐ **Maintenance:** Inject 90mg SC every 8 weeks; begin maintenance dosing 8 weeks after the IV induction dose		
	☐ OTHER				

PRESCRIBER INFORMATION

Physician Name (please print): _____ Contact Name: _____

NPI: _____ DEA: _____ Tax ID: _____

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

Phone: _____ Fax: _____ Email: _____

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for above patient. In order to expedite the process, please providechart notes and most recent labs.

Physician's Signature: _____ ☐ DAW (Dispense as Written) Date _____/_____/_____