PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

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

# GASTROENTEROLOGY ORDER FORM

**Ship to:** ☐ Patient ☐ Physician ☐ Other    All supplies, including syringes and needles, will be dispensed if needed.

## Patient Information

Patient Last Name: ________________ DOB: __________ SSN: __________

Address: ________________

City: ________________ State: ________ Zip: __________

Phone: ________________ Alt Phone: ________________

Alternate Contact Info: ________________

Allergies: ________________

**PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS**

## Clinical Information

Gender: ☐ Male ☐ Female BSA: ________

Height: __________ Weight: __________

TB test given: ☐ Yes ☐ No
Does patient have an active infection?
☐ Yes ☐ No

Start Date: ________________

Review Date: ________________

Diagnosis: Date of Diagnosis: ________________

- ☐ B18.1 Hepatitis B
- ☐ K58.0 IBS w/Diarrhea
- ☐ K50.90 Crohn's Disease
- ☐ K72.9 Hepatic Encephalopathy
- ☐ A09 Traveler's Diarrhea
- ☐ K51.90 Ulcerative Colitis
- ☐ K20.0 Eosinophilic Esophagitis

☐ Other Diagnosis: ICD-10 Code: ____________

Description: ________________

Tried and Failed History:

Medication: ________________ Duration: ________________

Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side Effects ☐ Other: ________________

## Prescription Information

| | Medication | Dose/Strength | | Directions | Qty | Refills |
|---|---|---|---|---|---|---|
| HBV | ☐ Vemlidy | ☐ 25mg | | ☐ Take 1 tablet by mouth once daily with food | 30 tab | ______ |
| HEPATIC | ☐ Xifaxan | ☐ 200mg<br>☐ 550mg | Drugs tried & failed:<br>☐ Lactulose ☐ Neomycin<br>☐ Other: ________<br>Date: ________ | ☐ **Traveler's Diarrhea:** Take 200mg PO TID x3days<br>☐ **Hepatic Encephalopathy:** Take 550mg PO BID<br>☐ **IBS w/Diarrhea:** Take 550mg PO TID x14days<br>☐ Other ________________ | 9 tab<br>60 tab<br>42 tab<br>_____ | None<br>______<br>None<br>______ |
| CROHNS DISEASE / ULCERATIVE COLITIS | ☐ Cimzia | ☐ Starter Kit 200mg<br>☐ 200mg/ml Prefilled syringe | | ☐ **Initial Dose:** Inject 400mg SQ once, then repeat at week 2 and 4<br>☐ **Maintenance:** Inject 400mg SQ every 4 weeks | 6 SYR<br>2 SYR | None<br>______ |
| | ☐ Humira | ☐ Citrate Free Crohn's/UC Starter Pack (80mg/0.8ml x3pens)<br>☐ Citrate Free 40mg/0.4ml Pen<br>☐ Citrate Free 40mg/0.4ml PFS | | ☐ **Initial Dose:** Inject 160mg SQ on day 1, then 80mg on day 15<br>☐ **Maintenance:** Inject 40mg SQ every other week starting day 29<br>☐ Other ________________ | 3<br>2 | None<br>______ |
| | ☐ Rinvoq | ☐ 15mg ER tablet<br>☐ 30mg ER tablet<br>☐ 45mg ER tablet | | ☐ **Initial Dose:** Take 45mg PO QD x8weeks<br>☐ **Maintenance:** Take 15mg PO QD<br>☐ Other ________________<br>*(Maintenance dose of 30mg QD may be considered for patients with refractory, severe, or extensive disease)* | 30<br>30<br>_____ | 1<br>______<br>______ |
| | ☐ Simponi | ☐ 100mg/ml autoinjector<br>☐ 100mg/ml prefilled syringe | | ☐ **Initial Dose:** Inject 200mg SQ at week 0, then 100mg at week 2<br>☐ **Maintenance:** Inject 100mg SQ every 4 weeks starting on week 6 | 3<br>1 | None<br>______ |
| | ☐ Stelara | ☐ 130mg/25mg SDV<br>☐ 90mg/ml Prefilled Syringe | | **Initial Dose:**<br>☐ **≤ 55kg:** 260mg (2 vials) IV as single dose<br>☐ **55kg to 85kg:** 390mg (3 vials) IV as single dose<br>☐ **> 85kg:** 520mg (4 vials) IV as single dose<br>☐ **Maintenance:** Inject 90mg SQ every 8 weeks; begin maintenance dose 8 weeks after the IV induction dose | 2 vials<br>3 vials<br>4 vials<br>1 SYR | None<br>None<br>None<br>______ |
| | ☐ Xeljanz | ☐ 5mg tablet<br>☐ 10mg tablet | | ☐ **Initial Dose:** 10mg PO BID x8weeks or ________ weeks<br>**Maintenance Dose:**<br>☐ 5mg PO BID ☐ 10mg PO BID | _____<br>60 tab | ______<br>______ |
| | ☐ Zeposia | ☐ Starter Kit<br>☐ 0.92mg capsules | | ☐ **Initial Dose:** Titration Regimen<br>Day 1-4: Take 0.23mg PO QD<br>Day 5-7: Take 0.46mg PO QD<br>Day 8 and thereafter: Take 0.92mg PO QD<br>☐ **Maintenance:** Take 0.92mg po QD | 1 Kit (37 caps)<br>30 caps | 0<br>______ |

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|---|---|---|---|---|---|
| OTHER | ☐ Lactulose Packet | ☐ 10gm/packet (lactulose powder, for solution): Dissolve contents of each packet in half a glass (4oz) of water before administration<br><br>(Check if applicable)<br>☐ I authorize to change to Lactulose 10gm/15ml solution if packet is not covered | **☐ Chronic Constipation**<br>Initial dose (check dose and duration):<br>☐ 10gm ☐ 20gm PO QD for _____ days<br>Additional therapy (check if applicable):<br>☐ 10gm ☐ 20gm ☐ 30gm ☐ 40gm PO QD | QS<br>_____ | None<br>______ |
| | | | **☐ Hepatic Encephalopathy (Treatment and Prophylaxis)**<br>Initial dose (check dose):<br>☐ 20gm ☐ 30gm PO every _____ hour until laxative achieved<br>Maintenance dose (check dose and frequency):<br>☐ 20gm ☐ 30gm PO ☐ TID ☐ QID | _____<br>_____ | ______<br>______ |
| | | | ☐ Other: ______________________________________________ | _____ | ______ |
| | ☐ Dupixent *(12+ years old, ≥ 40kg)* | ☐ 300mg/2ml Prefilled Pen<br>☐ 300mg/2ml Prefilled Syringe | ☐ Inject 300mg SQ every week | 4 | ______ |
| | ☐ Skyrizi | ☐ 600mg/10ml Vial<br>☐ 360mg/2.4ml Prefilled Cartridge | **☐ Initial Dose:** 600mg IV at week 0, 4, 8<br>**☐ Maintenance Dose:** 360mg SQ every 8 weeks starting at week 12 | 3 vials<br>1 | None<br>______ |
| | ☐ Other | ____________________________ | ☐ Other: ______________________________________________ | _____ | ______ |

## Prescriber Information

**PRIOR AUTHORIZATION**

Prescriber Name: ______________________________ NPI: ________________ DEA: ________________ LIC#: ____________________

Address: ______________________________________________________________________________________________

City: _________________________________ Zip: ___________ Tel: __________________________ Fax: _________________________

Contact Person: __________________________________________________________________________________________

**PRESCRIBER SIGNATURE**
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script.

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

**Physician's Signature:** _______________________________________ **☐ Dispense as written (DAW) Date:** ______/______/______

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