SMP PHARMACY SOLUTIONS

Fax#: 855-447-6637
Ph#: 855-650-5009

Gastro Prescription Faxable

Today's Date: _____ **Needed by:** _____ **Name:** _____ **Phone:** _____

Patient Demographic: (Provide the following or attached demographic sheet)

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____Alt. Phone: _____

SS#: _____ Date Birth: _____

Gender: _____ Height: _____ Weight_____ BSA ____ m2

Prescriber: (Provide as much information as possible)

Prescriber's Name: _____ Group/Hospital: _____

Specialty: _____ NPI #: _____ DEA: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Alt. Contact Name: _____ Ph: _____

Insurance Information (Please copy and attach the front and back of the Insurance Card):

Primary Insurance Name: _____ID#_____BIN#: _____ Group#: _____PCN#: _____ Phone:_____ □ No Insurance □ Patient will pay out of pocket □ Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):
□Patient Address □First Fill Physician's Office, Refill to Patient Address □Patient will pick up at Pharmacy

Diagnosis (ICD-10 code):
□ K50.10 Crohn's Disease □ K51.80 Ulcerative Colitis □ Other _____

Injection Training & Educational Needs: □ Specialty Pharmacy Injection Training Requested □ Manufacturer's Patient Assistance Program Enrollment Requested **OR** (Please Choose only one) □ Physician's Office already trained Patient □ Patient is already independently Injecting

Patient Allergies/ Allergic reactions
1. _____
2. _____

Prior (Failed) Medications (Reason for D/C)
1. _____
2. _____

Medication	Dose	Direction	Quantity	Refills
☐ **Cimzia**	☐ Cimzia Starter Kit ☐ 200mg/1 ml Prefilled Syr ☐ 200mg vial	☐ Crohns INDUCTION DOSE: Inj SC 400mg (2 vials) on day 1, and at weeks 2 and 4. ☐ Crohns MAINTENANCE DOSE: Inj SC 400mg (2 vials) every 4 weeks		
☐ **Entyvio** ☐ **Crohns** ☐ **Ulcerative Colitis**	☐ 300 mg infused IV single dose	☐ INDUCTION: IV at 300 mg at 0, 2, and 6 weeks. ☐ MAINTENANCE: IV at 300 mg every 8 weeks.		
☐ **Humira** ☐ **Crohns** ☐ **Ulcerative Colitis**	☐ 40mg Pen ☐ 40mg Prefilled Syr	☐ INDUCTION: Inj SC 160mg (4pens) on day 1, then 80ng (2pens) on day 15, then maintenance dosing. ☐ MAINTENANCE: Inj 40mg (1 injection) SC every other week. ☐ Other: _____		
☐ **Remicade** ☐ **Crohns** ☐ **Ulcerative Colitis**	☐ 100mg vial	☐ INDUCTION: IV at 5mg/kg (Does= _____mg) at 0, 2, and 6 weeks. ☐ MAINTENANCE: IV at 5mg/kg (Does= _____mg) every 8 weeks. ☐ Other: _____	(# of 100mg vials)	
☐ **Simponi**	☐ 100mg/1ml Prefilled Smartject autoinjector ☐ 100mg/1ml Prefilled Syr	☐ Ulcerative Colitis INDUCTION DOSE: 200mg initially administered by SC injection at week 0, followed by 100mg at week 2, and then 100mg every 4 weeks / ☐ Ulcerative Colitis MAINTENANCE DOSE: 100mg administered by SC injection every 4 weeks.		
☐ **Stelara**	☐ 45mg/0.5ml Prefilled Syr ☐ 90mg/1ml Prefilled Syr ☐ 5mg/1ml single dose vial	☐ Crohn's Disease INDUCTION DOSE: patients up to 55kg receive 260 mg, patients 55-85kg receive 390 mg and patients 85kg+ receive 520 mg via IV Infusion / ☐ Crohn's Disease MAINTENANCE DOSE: 90 mg subcutaneous 8 weeks after induction dose and 90 mg every 8 weeks thereafter		
☐ **Xifaxan** ☐ **IBS-D** ☐ **Hepatic Encephalopathy**	☐ 550 mg Tablets	☐ IBS-D - 1 tablet TID ☐ Hepatic Encephalopathy – 1 tablet BID	☐ 42 tablets ☐ 60 tablets	
☐ **Uceris**	☐ 9 mg Tablets	☐ 1 Tablet PO QD with or without food	☐ 30 tablets	☐ 8 week therapy
☐ **Other**				

By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature : _____ Date _____/_____/_____