Pharmacy Fax Number: _____

Faxed by: _____

GASTROENTEROLOGY
Prescription Form

Prescription Authorization

Completed ☐

Today's Date _____ Physician's Signature _____ ***(must be a wet signature)***

Physician Information

Completed ☐

First Name _____ Last Name _____ DEA# _____ License# _____

Practice Name _____ Contact Person _____ Direct Line _____

Address _____ City _____ State _____ ZIP _____ Prescriber Specialty _____

Phone _____ Fax _____ Email _____

Patient Information

Completed ☐

First Name _____ Last Name _____ ☐ Male ☐ Female

DOB _____ SSN# _____ Height _____ in Weight _____ lbs

Address _____ City _____ State _____ Zip _____

Cell Ph _____ Home Ph _____ Work Ph _____

Email Address _____ Allergies _____

Prescription Information

For alternate directions or dispense qty, please cross out and write in

Completed ☐

	Medication Prescribed	Strength	Sig (Directions for Use)	Disp Qty	Refills
☐	**Apriso** ® *(mesalamine XR)*	☐ ***0.375mg Capsules***	☐ *Take 4 capsules po qam (with or without food). Do not take antacids at the time of administration.*	*120 caps*	
☐	**Humira**® *(adalimumab)*	☐ ***Starter Kit*** *(Crohn's / UC)*	☐ *Inject 160mg subcutaneously at week 0 and 80mg at week 2 {Crohn's/UC Disease Starter Pack - six 40mg Pens w/ supplies}*	*6 Pens*	
		☐ ***40mg/0.8mL Pens*** ☐ ***40mg/0.8mL Pre-filled Syr***	☐ ***Maintenance Dose****: Inject 40mg subcutaneously q 2 weeks* ☐ ***Other****: Inject _____mg subcutaneously q _____ weeks*	*28 day supply*	
☐	**Linzess** ® *(linaclotide)*	☐ ***72mcg Caps*** ☐ ***145mcg Caps*** ☐ ***290mcg Caps***	☐ *Take 1 capsule po qam, on empty stomach 30 min prior to first meal*	*30 caps*	
☐	**Relistor** ® *(methylnaltrexone bromide)*	☐ ***150mg Tablet***	☐ *Take 3 tablets po qam, 30 min prior to first meal*	*90 tabs*	
		☐ ***12mg Pre-filled Syr*** *(injection)*	☐ *Inject 12mg subcutaneously qd*	*28 Syringes*	
☐	**Uceris** ® *(budesonide)*	☐ ***9mg ER Tablet***	☐ *Take 1 tablet po qd in the morning*	*30 tabs*	
		☐ ***2mg Rectal Foam***	☐ *Insert 1 applicatorful PR bid for 2 weeks, then use 1 qhs for 4 weeks*	*66.8gm*	
☐	**Xifaxan** ® *(rifaximin)*	☐ ***550mg Tablet***	☐ ***Hepatic Encephalopathy (HE)****: Take 1 tablet po bid*	*60 tabs*	
		☐ ***IBS-D Blister Card*** *(550mg tabs)*	☐ ***IBS-D****: Take 1 tablet po tid for 2 weeks*	*42 tabs*	
☐	**Viberzi** ® *(eluxadoline)*	☐ ***75mg Tablet***	☐ *Take 1 tablet po bid with food*	*60 tabs*	
		☐ ***100mg Tablet***	☐ *Take 1 tablet po bid with food*	*60 tabs*	
☐	***Other Rx:***	***Strength:***	***SIG:***	***Disp Qty:***	

Diagnosis / Clinical Information *(please provide clinical notes and labs to expedite Prior Authorization)*

Completed ☐

☐ *K50.90 Crohn's Disease NOS*
☐ *K50.00 Crohn's small intestine*
☐ *K50.10 Crohn's large intestine*
☐ *K51.90 Ulcerative Colitis (UC)*
☐ *K58 IBS-D*
☐ *K72.90 Hepatic Encephalopathy (HE) w/o coma*

SEVERITY
☐ *Mild*
☐ *Moderate to severe*
☐ *Fistulizing*

☐ ***Other Dx:*** _____

Has the patient had a ***NEGATIVE*** *tuberculin skin test, or if positive, has treatement for latent TB been initiated prior to anti-TNF therapy?*

☐ *YES* ☐ *NO* *TEST DATE:* _____

Does the patient have a ***clinically significant active infection****?* ☐ *YES* ☐ *NO*

Does the patient have ***NYHA Class III/IV CHF****?* *NO* ☐ *YES* ☐ ***Dx Date*** _____

Other MEDICAL CONDITIONS? _____

FOR MODERATE TO SEVERE CROHN'S DISEASE: *Has the patient failed or is contraindicated to optimal dosing/adequate duration of at least one of the following therapies:*

Corticosteroids, Mesalamine, Sulfasalazine, Immunomodulator (methotrexate, 5-mercaptopurine, azathioprine) ☐ ***NO*** ☐ ***YES*** _____

Is the patient currently on any therapy? ☐ ***YES*** ☐ ***NO*** ***If yes, list medications:*** _____

This form may be faxed to any pharmacy