HepCare Specialty Pharmacy
Committed • Accessible • Reliable • Experienced

GASTROENTEROLOGY AND HEPATOLOGY ENROLLMENT FORM

DATE: _____
DATE NEEDED: _____
SHIP TO: ☐ PATIENT ☐ OFFICE

FAX THIS FORM TO: 512-490-6515
2200 Park Bend Drive, Bldg 1,
Suite 300, Austin, Texas, 78758
Phone: [512] 381-1708 • Toll Free [855] 241-6658

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ ☐ MALE ☐ FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ MOBILE PHONE _____ SS# __ __ __ - __ __ __ - __ __ __ __

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL AND INSURANCE INFORMATION

Diagnosis Codes

Date of Diagnosis: _____

☐ K50.90 Crohn's Disease ☐ B18.1 Hepatitis B
☐ K51.90 Ulcerative Colitis ☐ K58.0 IBS w/ Diarrhea
☐ Hepatic Encephalopathy ☐ Other: _____

Treatment History

☐ New to this medicine ☐ Continued Treatment
If continuing treatment, has patient's condition improved or stabilized? ☐ Yes ☐ No

Patient Weight: _____ kg / lb Allergies? ☐ Latex ☐ NKDA
☐ Other Allergies? _____

Concomitant Medications: _____

Crohn's/UC Severity: ☐ Moderate ☐ Severe ☐ Mild (Uceris)

Presence of Enterocutaneous/Rectovaginal Fistulas? ☐ Yes ☐ No

Has patient been diagnosed with Heart Failure? ☐ Yes ☐ No

Has patient been diagnosed with Lymphoma? ☐ Yes ☐ No

Does patient have serious/active infection? ☐ Yes ☐ No

TB Test Performed? ☐ No ☐ Yes ☐ Result? _____

Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No - If Yes, has Hepatitis B been ruled out or treatment started? ☐ Yes ☐ No

☐ Other: _____

Prior Failed Medication(s)

Medication _____
Length of Treatment _____ **to** _____
Reason for Discontinuing _____
_____

☐ Other

Drug Name: _____
☐ Strength: _____ _____
☐ Directions: _____
_____
QTY: ☐ _____ | **Refills**_____

Manufacturer's Support: Is patient enrolled in the product manufacturer's sponsored support program? *(example: myHUMIRA, AccessOne)* ☐ Yes ☐ No

PRESCRIPTION INFORMATION

☐ Entecavir *(Hepatitis B)*

☐ 0.5mg Tablets
☐ 1mg Tablets
☐ **Dosing:**
☐ Take 1 tablet PO QD
QTY: ☐ 30 ☐ _____ | **Refills**_____

☐ Viread® *(Hepatitis B)*

☐ 300 mg Tablets
☐ **Dosing:**
☐ Take 1 tablet PO QD
☐ Other: _____
QTY: ☐ 30 ☐ _____ | **Refills**_____

☐ Vemlidy® *(Hepatitis B)*

☐ 25 mg Tablets
☐ **Dosing:**
☐ Take 1 tablet PO QD with food
☐ Other: _____
QTY: ☐ 30 ☐ _____ | **Refills**_____

☐ Cimzia® *(Crohn's)*

☐ **Starter Dose:**
☐ Starter Kit (200mg Pre-filled Syringe)
☐ Vial (200mg/ml) & supplies
☐ **Starter Directions:**
☐ Inject 400mg SC at weeks 0, 2, and 4
☐ Other: _____
QTY: ☐ 1 pre-fill syr KIT (6x200mg syr)
☐ 6 vials ☐ _____ | **Refills**_____

☐ **Maintenance Dose:**
☐ Pre-filled Syringe (200mg/ml)
☐ Vial (200mg/ml) & supplies
☐ **Maintenance Directions:**
☐ Inject 400mg SC every 4 weeks
☐ Other: _____
QTY: ☐ 2 pre-filled syr ☐ 4 vials
☐ _____ | **Refills**_____

☐ Entyvio® *(Crohn's/UC)*

☐ 300mg/20ml Vial
☐ **Initial Directions:**
☐ Administer 300mg via IV infusion at Weeks 0, 2, and 6, then maintenance dosing.
☐ Other: _____

☐ **Maintenance Directions:**
☐ Administer 300mg via IV infusion every 8 weeks.
☐ Other: _____
QTY: ☐ _____ vials | **Refills**_____

☐ Humira® *(Crohn's - UC)*

☐ Crohn's/Ulcerative Colitis Starter Kit
☐ **Induction Dose:**
☐ Inject 160mg (4 pens) SC on day 1 , then 80mg Kit(2 pens) on day 15, then maintenance dosing
☐ Other: _____
QTY: ☐ 1 KIT | **Refills**_____

☐ **Maintenance Dose:**
☐ Pen (40mg/0.8ml)
☐ 40mg/0.8ml Prefilled Syringe (PFS)
☐ **Maintenance Directions:**
☐ Pen: Inject 40mg (one pen) SC every other week
☐ PFS: Inject 40mg (one syringe) SC every other week
☐ Other: _____
QTY: ☐ 2 ☐ _____ | **Refills**_____

☐ Remicade® *(Crohn's/UC)*

☐ Vial (100mg/20ml)
☐ **Initial Dosing:**
☐ Administer 5 mg/kg (Dose = _____mg) at 0, 2, & 6 weeks, then q 8 weeks

☐ **Maintenance Dosing:**
☐ Administer _____mg/kg every _____ weeks
☐ Other: _____
QTY: ☐ ___Vials | **Refills**_____

☐ Simponi® *(UC)*

☐ SmartJect Autoinjector (100mg/ml)
☐ Prefilled Syringe (100mg/ml)
☐ **Initial Dosing:**
☐ Inject 200mg(2 autoinj/syringes) SC on week 0, then 100mg (1 autoinj/ syringe) on week 2, then 100mg (1 autoinj / syringe) every 4 weeks

☐ **Maintenance Dosing:**
☐ Inject 100mg (1 pen/syringe) SC every 4 weeks
QTY: ☐ 3 autoing/syr on first dispense, and 1 for refills
☐ 1 autoinj/syr
☐ _____ | **Refills**_____

☐ Stelara® *(Crohn's)*

☐ Vial 130mg/26ml (5mg/ml)
☐ ≤55kg: 2 vials (260mg)
☐ >55kg to 85kg: 3vials (390mg)
☐ >85kg: 4 vials (480mg)
☐ **Initial Dosing:**
☐ Administer _____mg via IV infusion as a single dose

☐ **Maintenance Dosing:**
☐ Inject 90mg SC 8 weeks after initial IV dose, then every 8 weeks thereafter
QTY: ☐ 1 pre-filled syringe | **Refills**____
☐ Other: _____

☐ Uceris® *(Crohn's/UC)*

☐ 9 mg Tablets (extended release)
☐ **Dosing:**
☐ Take 1 tablet PO QD in the AM with or w/o food for up to 8 wks
☐ Other: _____
QTY: ☐ 30 ☐ _____ | **Refills**_____

☐ Xifaxan®

☐ 550mg Tablets
☐ **Dosing:**
☐ Hepatic Encephalopathy – Take 1 tablet PO BID
☐ IBS-D-Take 1 tab PO-TID for 2 wks, can take up to 2 add. courses if IBS-D SXS Returns
☐ Other: _____
QTY: ☐ 60 ☐ 42 ☐ __ | **Refills**____

INJECTION TRAINING ☐ Patient has received injection training ☐ Physician Office to provide injection training ☐ Pharmacy to provide injection training

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____
Telephone: _____ Fax: _____ Email: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI # : _____ License # : _____ Tax ID # : _____ Medicaid Provider # : _____

_____ _____ * _____
PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.