MedBox

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GASTROENTEROLOGY TREATMENT ENROLLMENT FORM

PATIENT INFORMATION AND TREATMENT HISTORY – please attach a copy of the patient's insurance card

Name: | Date of Birth: | ☐ Male ☐ Female

Address: | City | State | Zip Code:

Primary Phone: | Secondary Phone: | Language:

Allergies (Required): ☐ NKDA | Height: | Weight: | SSN:

Therapy Shipping Options: ☐ Patient's Home ☐ Prescriber's Office ☐ Alternative Address:

New Medication Start ☐ Continuation of Treatment ☐ | If continuing treatment, has patient condition improved? ☐ Yes ☐ No

ICD – 10 / Diagnoses: | Concomitant / Cardiovascular Conditions:

Crohn's / UC Severity: ☐ Severe ☐ Moderate ☐ Mild
TB / PPD Test Results? ☐ Yes ☐ No | Result ________________
Does patient have serious or active infection: ☐ Yes ☐ No
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
If yes, has Hepatitis B treatment begun or been ruled out? ☐ Yes ☐ No

Presence of Enterocutaneous/Rectovaginal Fistulas? ☐ Yes ☐ No
Has Patient been diagnosed with Heart Failure? ☐ Yes ☐ No
Has Patient been diagnosed with Heart Failure? ☐ Yes ☐ No
Has Patient been diagnosed with Lymphoma? ☐ Yes ☐ No
Does BMI indicate obesity? ☐ Yes ☐ No

Prior Failed Medications, durations and discontinuation causes:

PRESCRIPTION INFORMATIONS

SIMPONI

☐ SmartJet Pen ☐ PF Syringe

☐ **Initial Dose**: inject 200 mg (2 pens / prefilled syringes) subcutaneously on week 0, then 100 mg (1 pens / prefilled syringes) subcutaneously on week 2, then maintenance dosing

☐ **Maintenance** Dosing: inject 100 mg (1 pen / PFS) subcutaneously every 4 weeks

Refills: ____

XELJANZ

Dosing
☐ 10 mg tablet ☐ 5 mg tablet

Directions: 1 tablet orally, taken twice daily

Quantity: ____

Refills: ____

CIMZIA

☐ **Initial Dose Starter Kit** (200 mg pre-filled syringe)
☐ **Initial Dose Vial** (200 mg / mL & supplies
Initial Directions: ☐ Inject 400 mg SQ at weeks 0, 2 and 4
☐ Other: ____________
Quantity: ☐ 1 Prefilled Syringe Starter Kit ☐ 6 vials

☐ **Maintenance Dose** (200 mg prefilled syringe)
☐ **Maintenance Dose Vial** (200 mg / mL & supplies
Maintenance Directions:
☐ Inject 400 mg SQ every 4 weeks
☐ Other: ____________
Quantity:
☐ 2 Prefilled Syringe
☐ 4 vials

Refills: ____

HUMIRA

Initial Dose
☐ CD/UC/HS Starter 6X40 mg pens
☐ Humira Pediatric Crohn's Starter Kit 3X40 mg prefilled syringes
☐ Humira Pediatric Crohn's Starter Kit 3X40 mg prefilled syringes

Maintenance Dose
☐ 40 mg / 0.8 ml pens
☐ 40 mg / 0.8 ml prefilled syringes
☐ 20 mg / 0.4 ml prefilled syringes

HUMIRA CITRATE FREE

Initial Dose
☐ Citrate free CD/UC/HS Starter 3 X 80 mg / 0.8 ml pens
☐ Citrate free Pediatric Starter Kit 3 X 80mg / 0.8 ml prefilled syringe
☐ Citrate free Pediatric Starter Kit 1 X 80mg / 0.8 ml prefilled syringe, 1 X 40 mg / 0.4 ml prefilled syringe

HUMIRA CITRATE FREE CONTINUED

Maintenance Dose
☐ 40 mg / 0.4 ml citrate free pens
☐ 40 mg / 0.4 ml citrate free prefilled syringes
☐ 20 mg / 0.2 ml citrate free prefilled syringes

STELARA

☐ **Maintenance Dose and Directions**: inject 1 90 mg/ml prefilled syringe subcutaneously every 8 weeks

Quantity: ____ **Refills**: ____

Date of Initiating Infusion:
____

Infusion Location:
____
Name of Facility

PRESCRIBER INFORMATION, SIGNATURE AND DATE – please sign and date below

Practice Name: | Office Contact:

Prescriber: | NPI: | DEA:

Practice Address: | City | State | Zip Code::

Office Phone: | Office Fax:

________________________ ________________________
Dispense as Written Date Substitution Permissible Date

☐ Check here to authorize MedBox and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf, "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge.

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