

1 PATIENT INFORMATION		2 ENROLLMENT CHECKLIST	
Written Date: _____ Need By Date: _____ Ship To: <input type="checkbox"/> Patient (All Fills) <input type="checkbox"/> Provider (1st Fill Only) <input type="checkbox"/> Provider (All Fills) <input type="checkbox"/> Other: _____	Patient Name: _____ Date of Birth: _____ SSN: _____ Address: _____ City, State, Zip Code: _____ Phone: _____ Email Address: _____ Preferred language: _____ Contact Person: _____	<input type="checkbox"/> Demographics <input type="checkbox"/> Insurance Cards and/or Info <input type="checkbox"/> Last 2 visit notes <input type="checkbox"/> TB Test Results (i.e. Quantiferon Gold or PPD; **only if rx for Biologic agents)	<input type="checkbox"/> Evidence of Diagnosis (i.e. colonoscopy and/or pathology reports) <input type="checkbox"/> Current medication list <input type="checkbox"/> Prior treatment history
3 SPECIAL INSTRUCTION			
Training: <input type="checkbox"/> Pharmacy will coordinate training for patient <input type="checkbox"/> Provider will provide training <input type="checkbox"/> Training not necessary		Delivery: _____	

4 DIAGNOSIS AND CLINICAL INFORMATION									
Diagnosis (ICD-10) _____ Date of Diagnosis _____ <input type="checkbox"/> K50 Regional Enteritis <input type="checkbox"/> K50.1 Crohns Large Intestine <input type="checkbox"/> K50.90 Crohns unspecified <input type="checkbox"/> B19.10 Hepatitis B <input type="checkbox"/> K50.8 Crohns Large & Small Intestine <input type="checkbox"/> K51 Ulcerative Colitis <input type="checkbox"/> K72.90 Hepatic Encephalopathy <input type="checkbox"/> K58.0 Irritable Bowel Syndrome with Diarrhea (IBS-D) Other: _____									
Has patient had positive TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last chest x-ray: _____ Height: _____ Weight: _____ Allergies: _____									
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;">Previously Tried/Failed Medications- include dosage and frequency</th> <th style="width: 20%; text-align: left;">Date of Trial</th> <th style="width: 50%; text-align: left;">Reason for Discontinuation</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Previously Tried/Failed Medications- include dosage and frequency	Date of Trial	Reason for Discontinuation						
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5 PRESCRIPTION INFORMATION
INFLAMMATORY BOWEL DISEASE
CIMZIA® <input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200mg/1 mL Prefilled Syringe <input type="checkbox"/> 200mg Vial <input type="checkbox"/> Crohns INDUCTION DOSE: Inject subcutaneously 400mg (2 vials) on day 1, and at weeks 2 and 4. <input type="checkbox"/> Crohns MAINTENANCE DOSE: Inject subcutaneously 400mg (2 vials) every 4 weeks. Quantity: _____ Refills: _____
STELARA® 90mg/mL PREFILLED SYRINGE <input type="checkbox"/> Crohns MAINTENANCE DOSE: Inject 90mg (1 prefilled syringe) subcutaneously 8 weeks after the initial intravenous dose, then every 8 weeks thereafter <input type="checkbox"/> #1 Syringe + 5 refills <input type="checkbox"/> Quantity: _____ Refills: _____
HUMIRA® <input type="checkbox"/> Crohns <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Prefilled Syringe <input type="checkbox"/> INDUCTION & MAINTENANCE: Inject 160mg (4 injections) SC on day 1, then 80mg (2 injections) on day 15, then 40mg (1 injection) every other week. <input type="checkbox"/> MAINTENANCE ONLY: Inject 40mg (1 injection) SC every other week. <input type="checkbox"/> Other _____ Quantity: _____ Refills: _____
SIMPONI™ <input type="checkbox"/> Ulcerative Colitis INDUCTION DOSE: 200 mg initially administered by subcutaneous injection at Week 0, followed by 100 mg at Week 2, and then 100 mg every 4 weeks. <input type="checkbox"/> Ulcerative Colitis MAINTENANCE DOSE: 100 mg administered by subcutaneous injection every 4 weeks Quantity: _____ Refills: _____
XIFAXAN® 550mg TABLETS (RIFAXIMIN) <input type="checkbox"/> Hepatic Encephalopathy: Take 1 tablet by mouth twice daily <input type="checkbox"/> #60 + 11 refills <input type="checkbox"/> Quantity: _____ Refills: _____ <input type="checkbox"/> IBS-D: Take 1 tablet by mouth three times daily x 14 days, may treat recurrence up to 2 times <input type="checkbox"/> #42 + 2 refills <input type="checkbox"/> Quantity: _____ Refills: _____
VIBERZI™ (C IV) <input type="checkbox"/> VIBERZI™ 100mg Tablets <input type="checkbox"/> VIBERZI™ 75mg Tablets <input type="checkbox"/> IBS-D: Take 1 tablet (100mg) by mouth twice daily with food <input type="checkbox"/> IBS-D: Take 1 tablet (75mg) by mouth twice daily with food <input type="checkbox"/> #60 + 4 refills <input type="checkbox"/> Quantity: _____ Refills: _____
HEPATITIS B <input type="checkbox"/> Vemlidy® 25mg <input type="checkbox"/> Viread® 300mg <input type="checkbox"/> Baraclude® 0.5mg <input type="checkbox"/> Baraclude® 1mg <input type="checkbox"/> Epivir HBV® 100mg <input type="checkbox"/> Hepsera® 10mg <input type="checkbox"/> Tyzeka® 600mg Directions: _____ Quantity: _____ Refills: _____

6 PROVIDER AUTHORIZATION & INFORMATION					
By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Dolphin Health to act as the prescriber's agent to begin and To execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.					
<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____
<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____
<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____
Address: _____	Phone: _____	Fax: _____	Contact Person: _____		
Date: _____	Provider Signature: _____				<input type="checkbox"/> Do not substitute