Dolphin Health Rx
Committed to Helping People Get Well

GASTROENTEROLOGY ENROLLMENT FORM

Toll Free: 844-436-5744
Local Phone: 510-900-3131
Fax: 844-329-6979

1 PATIENT INFORMATION

Written Date:
Need By Date:

Ship To:
- ☐ Patient (All Fills)
- ☐ Provider (1st Fill Only)
- ☐ Provider (All Fills)
- ☐ Other: _____

Patient Name:
Date of Birth:
SSN:
Address:
City, State, Zip Code:
Phone:
Email Address:
Preferred language:
Contact Person:

2 INSURANCE INFORMATION

- ☐ Demographics
- ☐ Insurance Cards and/or Info
- ☐ Last 2 visit notes
- ☐ TB Test Results (i.e. Quantiferon Gold or PPD; **only if rx for Biologic agents)
- ☐ Evidence of Diagnosis (i.e. colonoscopy and/or pathology reports)
- ☐ Current medication list
- ☐ Prior treatment history

3 SPECIAL INSTRUCTION

Training:
- ☐ Pharmacy will coordinate training for patient
- ☐ Provider will provide training
- ☐ Training not necessary

Delivery: _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10)

Date of Diagnosis _____

- ☐ K50 Regional Enteritis
- ☐ K50 .1 Crohns Large Intestine
- ☐ K50.90 Crohns unspecified
- ☐ B19.10 Hepatitis B
- ☐ K50.8 Crohns Large & Small Intestine
- ☐ K51 Ulcerative Colitis
- ☐ K72.90 Hepatic Encephalopathy
- ☐ K58.0 Irritable Bowel Syndrome with Diarrhea (IBS-D)

Other: _____

Has patient had positive TB test? ☐ Yes ☐ No If yes, date of last chest x-ray: _____
Height: _____ Weight: _____ Allergies: _____

Previously Tried/Failed Medications- include dosage and frequency	Date of Trial	Reason for Discontinuation

5 PRESCRIPTION INFORMATION

INFLAMMATORY BOWEL DISEASE

CIMZIA® ☐ Cimzia Starter Kit ☐ 200mg/1 mL Prefilled Syringe ☐ 200mg Vial

- ☐ Crohns INDUCTION DOSE: Inject subcutaneously 400mg (2 vials) on day 1, and at weeks 2 and 4.
- ☐ Crohns MAINTENANCE DOSE: Inject subcutaneously 400mg (2 vials) every 4 weeks.

Quantity: _____ Refills: _____

STELARA ® 90mg/mL PREFILLED SYRINGE

- ☐ Crohns MAINTENANCE DOSE: Inject 90mg (1 prefilled syringe) subcutaneously 8 weeks after the initial intravenous dose, then every 8 weeks thereafter
- ☐ #1 Syringe + 5 refills
- ☐ Quantity: _____ Refills: _____

HUMIRA® ☐ Crohns ☐ Ulcerative Colitis ☐ 40mg Pen ☐ 40mg Prefilled Syringe

- ☐ INDUCTION & MAINTENANCE: Inject 160mg (4 injections) SC on day 1, then 80mg (2 injections) on day 15, then 40mg (1 injection) every other week.
- ☐ MAINTENANCE ONLY: Inject 40mg (1 injection) SC every other week.
- ☐ Other _____

Quantity: _____ Refills: _____

SIMPONI™ ☐ 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.

☐ Ulcerative Colitis MAINTENANCE DOSE: 100 mg administered by subcutaneous injection every 4 weeks

Quantity: _____ Refills: _____

XIFAXAN® 550mg TABLETS (RIFAXIMIN)

- ☐ Hepatic Encephalopathy: Take 1 tablet by mouth twice daily
- ☐ #60 + 11 refills ☐ Quantity: _____ Refills: _____
- ☐ IBS-D: Take 1 tablet by mouth three times daily x 14 days, may treat recurrence up to 2 times
- ☐ #42 + 2 refills ☐ Quantity: _____ Refills: _____

VIBERZI ™(C IV)

- ☐ VIBERZI ™ 100mg Tablets ☐ VIBERZI ™ 75mg Tablets
- ☐ IBS-D: Take 1 tablet (100mg) by mouth twice daily with food ☐ IBS-D: Take 1 tablet (75mg) by mouth twice daily with food
- ☐ #60 + 4 refills ☐ Quantity: _____ Refills: _____

HEPATITIS B

- ☐ Vemlidy® 25mg ☐ Viread® 300mg ☐ Baraclude® 0.5mg ☐ Baraclude® 1mg
- ☐ Epivir HBV® 100mg ☐ Hepsera® 10mg ☐ 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.

Prescriber Name: _____ Address: _____
DEA: _____ NPI: _____ City, State, ZIP Code: _____
Phone: _____ Fax: _____ Contact Person: _____
Date: _____ Provider Signature: _____ ☐ Do not substitute

02/15/2017