DolphinHealth 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

Today's 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

PLEASE FAX A COPY (FRONT AND BACK) OF PATIENT'S CURRENT ACTIVE INSURANCE AND ID CARDS. FOR PATIENTS WITH BOTH MEDICARE AND MEDI-CAL, PLEASE FAX IN COPIES FOR BOTH.

3 SPECIAL INSTRUCTION

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

Delivery: ____________

4 CLINICAL INFORMATION

PLEASE FAX COPIES OF RECENT CHART NOTES, LABS, EVIDENCE OF DIAGNOSIS, AND CURRENT MEDICATION LIST.

5 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

6 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: ____________

7 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

17/11/2016