ahma(rx)

GASTROENTEROLOGY

Toll free phone: 844.749.6628
Toll free fax: 888.966.0647

Patient Information – *Please attach a copy of the patient's insurance card*

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:		Language:
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:

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

Prescriber Information

Practice Name:		Office Contact:	
Prescriber :		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

Diagnosis/ICD -10:	Prior Failed Medications:
Is Hepatitis B ruled out? ☐ Yes ☐ No If no, has treatment started? ☐Yes ☐ No	TB/PPD test given/intended to be given before start? ☐ Yes ☐ No If yes, please attach all available lab results :

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Cimzia®	☐ Prefilled syringe starter kit	Induction dose: 400 mg Sub-Q at weeks 0, 2, and 4	☐ 1 starter kit (6 prefilled syringes)	0
	☐ 200 mg/mL prefilled syringe	Maintenance dose: ☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 1 unit (2 prefilled syringes)	
☐ Donnatal ®	☐ 16.2 mg/5 mL Elixir	☐ Take ____ mL by mouth _____ daily (elixir)	☐118 mL ☐473 mL	
	☐ 16.2 mg tablets	☐ Take _____ tablets by mouth ____ times daily	☐90 tablets☐240 tablets☐ __tablets	
☐ Entyvio®	☐ 300 mg vial	☐ 300 mg infused IV at 0, 2 and 6 weeks, then every 8 weeks thereafter.	___# of 300 mg vials	
☐ Humira®	☐ 40 mg pens ☐ 40 mg prefilled syringe	Induction dose: ☐ Adults and children ≥ 88 lbs.: 160 mg Sub -Q day 1, 80 mg day 15 , 40 mg day 29 and every other week thereafter	☐ 1 starter kit (6 pens) ☐ 3 units (6 prefilled syringes)	0
	☐ 40 mg pens ☐ 40 mg prefilled syringe	Maintenance dose: ☐ Adults and childr en ≥ 88 lbs.: 40 mg Sub -Q every other week	☐ 1 unit (2 pens) ☐ 1 unit (2 prefilled syringes)	
☐ Simponi®	☐ 100 mg/mL SmartJect® ☐ 100 mg/mL prefilled syringe	Induction dose: ☐ 200 mg Sub-Q at week 0, 100 mg at week 2 and every 4 weeks thereafter	☐ 3 SmartJect® autoinjectors ☐ 3 prefilled syringes	0
		Maintenance dose: ☐ 100 mg Sub -Q every 4 weeks	☐ 1 SmartJect® autoinjector ☐ 1 prefilled syringe	
☐ Stelara®	☐ 90 mg prefilled syringe	Induction dose date: ____ \ ____ \ ______	1 prefilled syringe	
		Maintenance dose: ☐ Inject 1 syringe Sub -Q every 8 weeks after induction		
☐ Xifaxan®	☐ 200 mg tablets	☐ Take one tablet by mouth three times daily for three days (Travelers' Diarrhea)	☐ 9 tablets	
	☐ 550 mg tablets	☐ Take one tablet by mouth twice daily with or without food (Hepatic Encephalopathy)	☐ 42 tablets	
		☐ Take one tablet by mouth three times daily for 14 days (IBS-D)	☐ 60 tablets	
☐ Uceris®	☐ 9mg tablets ☐ 2mg/dose foam	☐ Take one tablet by mouth once daily in the morning with or without food	☐ 30 tablets ☐ 60 tablets	
		☐ Insert and administer 1 metered dose twice daily for two weeks followed by 1 metered dose once daily (foam)	☐ 2 week supply ☐ 6 week supply	

Other Medications

Medication	Dose	Directions	Quantity	Refills
☐ Amitiza®	☐ 24 mcg capsules ☐ 8 mcg capsules	☐ Take one 24 mcg capsule twice daily (CIC & OIC) ☐ Take one 8 mcg capsule twice daily (IBS-C)	60 capsules	
☐ Linzess®	☐ 72 mcg capsules ☐ 145 mcg capsules ☐ 290 mcg capsules	☐ Take one capsules by mouth daily	30 tablets	
☐ Movantik ®	☐ 25 mg tablets	☐ Take 1 tablet by mouth daily in the morning	90 tablets	
☐ Relistor®	☐ 150 mg tablets	☐ Take 3 tablets by mouth daily	90 tablets	
☐ Trulance®	☐ 3 mg tablets	☐ Take one tablet by mouth daily	30 tablets	

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: ______________________ ______________________
Date

CONFIDENTIALITY NOTICE: This form and its contents may contain private and confidential information that is intended for the individual or entity to which it is addressed. Any transmission of this form may contain information that is exempt from disclosure under laws including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Unless explicitly stated, you are strictly prohibited from disseminating, copying or distributing any material contained within. Violators will be prosecuted to the fullest extent of the law. If you received this communication in error, please notify us immediately and destroy this form and its contents.