Gastroenterology Enrollment Form

Phone: 713-360-2100 or 1-855-497-7956 | **Fax:**713-360-2105 or 1-855-497-7957

Ship To: Patient Physician Other **Ship By:** ____________________

Patient Information

Name: ____________________
DOB: __________ Gender: M F SSN: ____________
Language: Eng Span Other:________ Weight: ______ Lbs Kgs
Address: ____________________
City: ____________ State: ______ Zip: ________
Home #: ____________ Work #: ____________
Cell #: ____________
Allergies: ____________________ NKDA

Prescriber Information

Prescriber: ____________________
DEA: ____________ NPI: ____________
Address: ____________________
City: ____________ State: ______ Zip: ________
Phone #: ____________________
Cell #: ____________ Fax #: ____________
Office Contact: ____________________
Initiate Appeal Reason: ____________________

**** INSURANCE INFORMATION: PLEASE FAX COPY OF PRESCRIPTION CARD, FRONT AND BACK AS WELL AS ALL CLINIC NOTES ****

Clinical Information

DIAGNOSIS (Description & ICD 10 Code): ____________________ **Current Medications:** ____________________

Has Patient been treated previously for this condition Yes No

NSAIDS	____________	Duration: ______	Sulfasalazine	____________	Duration: ______
Corticosteroids	____________	Duration: ______	5-ASA (5-aminosalicylates)	____________	Duration: ______
MTX	____________	Duration: ______	6-MP (6-mercaptopurine)	____________	Duration: ______
Azathioprine	____________	Duration: ______	REMICADE infusion	____________	Duration: ______
Other prior BIOLOGIC use:	____________	Duration: ______	Other:	____________	Duration: ______

Number of ENDOSCOPIES ______
Is Patient currently on any therapy? Yes No List Meds: ____________________
Will patient stop taking Meds before starting new meds? Yes No If Yes: ____________________
Has patient received PPD? Yes No Results: ____________________

Medication	Strength		Directions	QTY	Refill
Cimzia	Starter:	200mg Prefilled Syringe Starter Kit (6 doses) 200mg Vial X 3 Cartons (6 doses)	Inject TWO 200mg (400mg) subcutaneously at weeks 0, 2 and 4	4 week supply	0
	Maintenance:	200mg Prefilled Syringe Starter Kit (2 doses) 200mg Prefilled Syringe (2 doses / kit)	Inject TWO 200mg (400mg) subcutaneously every 4 weeks Inject 200mg subcutaneously every 2 weeks	4 week supply	
Entyvio	Initial:	300mg Vial	Infuse 300mg IV over 30 minutes at week 0, 2 and 6 Include Sterile Water diluent and 250ml NaCL for infusion	3	0
	Maintenance:	300mg Vial	Infuse 300mg IV over 30 minutes every 8 weeks Include Sterile Water diluent and 250ml NaCL for infusion	1	
Humira	Starter:	Crohn's/UC Starter Pack	Inject 160 mg subcutaneously on Day 1, then 80 mg on Day 15 Inject 80 mg subcutaneously on Day 1 and Day 2 consecutively, then 80 mg on Day 15	1 kit	0
	Maintenance:	40mg Pen (2 doses / kit) 40mg Prefilled Syringe (2 doses / kit)	Inject 40mg subcutaneously every other week	1 kit	
Remicade Inflectra	Initial:	100mg Vial	Infuse ______ mg/kg = ______ mg at 0, 2, and 6 weeks	Pharmacist to QS	0
	Maintenance:	100mg Vial	Infuse ______ mg/kg = ______ mg every ______ weeks	Pharmacist to QS	
Simponi	Starter:	100mg SmartJect 100mg Prefilled Syringe	Inject TWO 100mg (200mg) subcutaneously at week 0, then 100mg on week 2	3	0
	Maintenance:	100mg SmartJect 100mg Prefilled Syringe	Inject 100mg subcutaneously every 4 weeks	1	
Stelara	Initial IV:	**Weight**			Zero
		Up to 55 kg	Infuse 260 mg (2 vials) intravenously X 1 at week 0	2	
		Greater than 55 kg to 85 kg	Infuse 390 mg (3 vials) intravenously X 1 at week 0	3	
		Greater than 85 kg	Infuse 520 mg (4 vials) intravenously X 1 at week 0	4	
	Maintenance SQ:	All Weights	Inject 90 mg subcutaneously 8 weeks after intial intravenous dose, then every 8 weeks thereafter	1	
Xeljanz	Starter:	10 mg tab	Take 1 tablet PO 2 times a day for 8 weeks	8 week supply	0
	Maintenance:	5 mg tab 10 mg tab	Take 1 tablet PO 2 times a day	4 week supply	
Xifaxan	550mg Tab		Take 1 tablet PO 2 times a day	60	0
			Take 1 tablet 3 times a day X 14 days	42	

Additional Information: ____________________

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Prescriber Signature: ____________________ **Date:** __________

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing BioCure LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-pay Assistance Foundations