WELLPARTNER PHARMACY | GASTROENTEROLOGY ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /

Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ B16.9 Acute hepatitis B w/o delta-agent or hepatic coma
◯ B18.1 Chronic viral hepatitis B w/o delta-agent
◯ K50.00 Crohn's disease of small intestine w/o complications
◯ K50.10 Crohn's disease of large intestine w/o complications
◯ K50.80 Crohn's disease of small and large intestine w/o complications
◯ K50.90 Crohn's disease, unspecified, w/o complications
◯ K51.80 Other ulcerative colitis without complications
◯ Other:

Crohn's severity: ◯ Moderate ◯ Severe ◯ N/A

Prior (failed) medications:

Allergies

Current Medications:

Height (in/cm): Weight (lb/kg):

Enterocutaneous/rectovaginal fistulas? ◯ Yes ◯ No

Has patient been diagnosed with heart failure? ◯ Yes ◯ No

Has patient been diagnosed with lyphoma? ◯ Yes ◯ No

Does patients have serious/active infection? ◯ Yes ◯ No

Has TB test been performed? ◯ Yes ◯ No If yes, results:

Is patient at risk for hepatitis B infection? ◯ Yes ◯ No

If yes, has hepatitis B been ruled out or treatment initiated? ◯ Yes ◯ No

Does patient have a latex allergy? ◯ Yes ◯ No

Are there any contraindications to previous treatments? ◯ Yes ◯ No

If yes, drug: Reason:

Does patient require injection training? ◯ Yes ◯ No

If no, reason: ◯ Patient is independent
◯ Patient trained by MD or referred to alternate trainer

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Baraclude™	◯ 0.5 mg ◯ 1 mg			
◯ Cimzia™	◯ Cimzia starter kit	◯ Induction dose: Inject SQ 400 mg (2 vials) on day 1, and at weeks 2 and 4.	1 kit (6 vials)	
	◯ 200 mg/1 ml PFS ◯ 200 vial	◯ Maintenance dose: Inject SQ 400 mg (2 vials) every 4 weeks. ◯ Other:	1 kit (2 vials)	
◯ Epivir HBV™	100 mg			
◯ Hepsera™	10 mg			
◯ Humira™	◯ Crohn's starter package	◯ Induction dose: Inject SQ 160 mg (4 pens) on day 1, then 80 mg (2 pens) on day 15, then maintenance dosing	1 kit	
	◯ 40 mg self injectable pen ◯ 40 mg PFS	◯ Maintenance dose: Inject SQ 40 mg (one pen) every other week. ◯ Maintenance dose: Inject SQ 40 mg (one syringe) every other week.	1 kit	
◯ Remicade™	◯ 100 mg vial _____ mg/kg	◯ Induction dose: IV at 5 mg/kg (Dose = _____ mg) at 0, 2, and 6 weeks. ◯ Maintenance dose: IV at 5 mg/kg (Dose = _____ mg every 8 weeks) ◯ Other:	# of 100 mg vials: _____	
◯ Simponi™		◯ Induction dose: Inject 200 mg SQ initially, followed by 100 mg at week 2, and then 100 mg and then 100 mg every 4 weeks ◯ Maintenance dose: Inject 100 mg SQ every 4 weeks		
◯ Solesta™	◯ Four 1ml PFS w/ needles			
◯ Tysabri™				
◯ Tyzeka™ (LD)*	(LD)* This is a limited distribution drug that requires additional handling. Please call (1.800.473.3516) for more information.			
◯ Viread™				
◯ Zorbtive™	8.8 mg vial			

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE