TFP WELLNESS SYSTEMS
Your Lifetime Pharmacy Solution

GASTROENTEROLOGY ENROLLMENT FORM

Phone: (813) 871-5161 ext. 34993
Fax: (813) 877-2479

PATIENT INFORMTION (OR ATTACH PATIENT DEMOGRAPHIC SHEET)					
Patient Name:	☐Male ☐Female	Allergies:			☐NKDA
Date of Birth:	SSN:		Weight:	☐kg ☐lb Date:	
Address:		City:		State:	Zip:
Phone # (Home):	Work #:	Email (Optional):			

INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF MEDICAL AND PRESCRIPTION CARDS, IF AVAILABLE)		
Primary Insurance:	RX Bin:	RX PCN:
RX Group:	RX ID:	RX Phone:
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SSN:

DIAGNOSIS/MEDICAL INFORMATION (COMPLETE CLINICAL INFO BELOW OR ATTACH PATIENTS LABS)

☐ K50.90 Crohn's Disease NOS	☐ K50.91 Crohn's Disease with complications	☐ Other:
☐ K50.00 Crohn's Small Intestine without complications	☐ K51.90 Ulcerative Colitis without complications	
☐ K50.10 Crohn's Large Intestine without complications	☐ K51.91 Ulcerative Colitis with complications	

Severity type:	Has the patient had a NEGATIVE tuberculin skin test, or if positive, has treatment for latent TB been initiated prior to anti-TNF therapy?	Does the patient have NYHA Class III/IV CHF?	Does the patient have a clinically important active infection?
☐ Mild ☐ Moderate to severe ☐ Fistulizing	☐ YES ☐ NO Test date: _____	☐ YES ☐ NO	☐ YES ☐ NO If yes:_____

For moderate to severe Crohn's disease: Has patient failed/contraindicated to optimal dosing/adequate duration of at least one of the following therapies: ☐ **YES** ☐ **NO**
Corticosteroids, Mesalamine or Sulfasalazine, Immunomodulator (methotrexate, 6-mercaptopurine, azathioprine)
Is the patient currently on any therapy? ☐ **YES** ☐ **NO**

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Cimzia® (certolizumab pegol)	☐ 200mg Pre-filled Syringes Starter Kit ☐ 200mg Pre-filled Syringes	☐ Initial Dose: 400mg subcutaneously at weeks 0,2 and 4 ☐ Maintenance Dose: 400mg subcutaneously every four weeks		
☐ Entyvio ® (vedolizumab)	☐ 300mg Powdered Vial	☐ Initial Dose: 300mg IV infused over 30 minutes at week 0, 2 and 6 ☐ Maintenance Dose: 300mg IV infused over 30 minutes every 8 weeks after initial dosing		
☐ Humira CF® (adalimumab)	☐ 80mg / 0.8mL Pens	☐ Initial Dose: Inject 2 pens (160mg) subcutaneously on day 1 and inject 1 pen (80mg) on day 15		
	☐ 40mg / 0.4mL Pens	☐Maintenance Dose: 40mg subcutaneously every other week ☐ Maintenance Dose: 40mg subcutaneously every _____ weeks		
☐ Humira® (adalimumab)	☐ Crohn's / UC Starter Kit	☐ Initial Dose: Inject 2 pens (80mg) subcutaneously on day 1, then inject 2 pens (80mg) on day 2, then inject 2 pens (80mg at week 2 ☐ Initial Dose: Inject 4 pens (160mg) subcutaneously on day 1 then inject 2 pens (80mg) at week 2		
	☐ 40mg / 0.8mL Pens	☐ Maintenance Dose: 40mg subcutaneously every other week ☐ Maintenance Dose: 40mg subcutaneously every _____ weeks		
☐ Remicade® Auto injector (infliximab)	☐ 100mg Vial	☐ Initial Dose: 5mg/kg at week 0, 2 and 6. Patients weight: _____ x 5mg = _____mg ☐ Maintenance Dose: 5mg/kg every 8 weeks. Patients weight: _____ x 5mg = _____mg		

DELIVERY INSTRUCTIONS

☐ Physician's Office ☐ Patient's Home ☐ 1st dose MD office, Refills to patient's home

PHYSICIANS CONTACT INFORMATION & AUTHORIZATION

Physician's Name:	Office Contact:	Institution:
Phone #:	Fax #:	Specialty:
Address:	City/State/Zip:	
Tax ID:	DEA #:	NPI #:
Physician's Signature:	Date:	

*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), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that 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. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original document. Created:08/28/18 Revised: 05/01/19, 08/22/19, 02/04/20

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Is the patient currently on any therapy? ☐ **YES** ☐ **NO**

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Simponi® UC (golimumab)	☐ 100mg SmartJect® Auto Injector ☐ 100mg Pre-filled Syringe	☐ Initial Dose: 200mg subcutaneously at week 0, followed by 100mg at week 2 ☐ Maintenance Dose: 100mg subcutaneously once every four weeks		
☐ Stelara ® (ustekinumab)	☐ 90mg / mL Syringe ☐ 45mg / mL Syringe ☐ 130mg / 26mL Vial	☐ Initial Dose: A single IV infusion using weight-based dosing (patient weight in kg): ☐ Up to 55 kg or less — 260 mg (2 vials) ☐ Greater than 55 kg to 85 kg — 390 mg (3 vials) ☐ Greater than 85 kg — 520 mg (4 vials) ☐ Maintenance Dose: 90mg SQ 8 weeks after initial IV dose, then every 8 weeks thereafter		
☐ Xeljanz® (tofacitinib)	☐ 5mg Tablet ☐ 10mg Tablet	<u>Ulcerative Colitis:</u> ☐ Initial Dose: 10mg twice daily for at least 8 weeks ☐ Maintenance Dose: ☐ 5mg twice daily ☐ 10mg twice daily ***Discontinue after 16 weeks of 10mg twice daily if adequate response not achieved. Use the lowest effective dose to maintain response.**		

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PHYSICIANS CONTACT INFORMATION & AUTHORIZATION		
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Phone #:	Fax #:	Specialty:
Address:	City/State/Zip:	
Tax ID:	DEA #:	NPI #:
Physician's Signature:		Date:

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