Gastroenterology / Crohn's / UC

Fax Referral to: 512-487-5033 Phone: 512-432-5190
Email Referral to: april@martinsspecialtypharmacy.com

Patient Information

Patient Name
Address
City, State, Zip
Primary Phone Emergency Contact Name & Phone Number
Date of Birth ☐ Male ☐ Female
Social Security #

Prescriber Information

Prescriber Name
DEA# NPI# License #
Address
City, State, Zip
Phone Fax
Contact Person

Insurance Information:

Please fax FRONT and BACK copy of prescription and medical insurance cards.

Diagnosis/Clinical Information:

Please fax recent clinical notes, labs and tests with this prescription to expedite the Prior Authorization

Diagnosis: ☐ K50.00 Crohn's Disease Small Intestine ☐ K50.10 Crohn's Disease Large Intestine ☐ K50.80 Crohn's Disease Large & Small Intestine
☐ K50.90 Regional Enteritis NOS ☐ K51.90 Ulcerative Colitis Unspecified ☐ Other: ICD code ________ Condition: ________
☐ K72 Hepatic Failure unclassified ☐ K72.90 Hepatic Failure w/o Coma ☐ K58.0 IBS w/ Diarrhea

Has the patient been previously treated for this condition? ☐ Yes ☐ No Prior failed Medications:

☐ Azathioprine Duration ________ ☐ Corticosteroids Duration ________ ☐ Sulfasalazine Duration ________
☐ 5-ASA (5-Aminosalicylate Duration ________ ☐ MTX Duration ________ ☐ 6-MP (6-Mercaptopurine) Duration ________
☐ Biologics Duration ________ ☐ NSAIDS Duration ________ ☐ Others: Duration ________

Is the patient currently on therapy? ☐ Yes ☐ No Medication(s): ________

Will patient stop current therapy before starting new therapy? ☐ Yes ☐ No Stop Date: ________ Waiting period for new therapy: ________

Other medications patient taking: ________

TB/PPD Test Given? ☐ Yes ☐ No Date of Negative TB Test: ________

Hepatitis B Ruled Out? ☐ Yes ☐ No If Hep B not ruled out, treatment started? ☐ Yes ☐ No

Allergies: ________ Height: ________ Weight: ________

Prescription Information

Medication	Dose / Strength	Directions	Quantity	Refills
Cimzia®	☐ Cimzia Starter Kit	☐ Starter Kit Induction Dose: Inject 400mg Sub-Q (2 x 200mg syringes) on day 1, and at weeks 2 and 4	☐ 1 Kit (includes 6 Prefilled Syringes)	0
	☐ 200mg/ml Prefilled Syringe ☐ 200mg vial	☐ Inject 400mg (2 injections) Sub-Q every 4 weeks	☐ 4 week supply	____
Humira®	☐ Crohn's Starter Kit	☐ Inject 160mg Sub-Q ☐ 4 x 40mg injections on day 1 **OR** ☐ 2 x 20mg injections on days 1&2 Then inject 80mg Sub-Q (2 x 40mg injections) on day 15	☐ 1 Kit	0
	☐ 40mg Pen ☐ 40mg Prefilled Syringe	☐ Inject 40mg Sub-Q every other week, starting week 4	☐ 4 week supply	____
Simponi®	☐ 100mg SmartJect Autoinjector ☐ 100mg Prefilled Syringe	☐ Inject 200mg Sub-Q (2 x 100mg syringes) at week 0, then inject 100mg Sub-Q at week 2, then inject 100mg Sub-Q every 4 weeks	☐ 4 Syringes	0
		☐ Inject 100mg Sub-Q every 4 weeks	☐ 4 week supply	____
Xifaxan®	☐ 550mg Tablets Starter Pack	☐ Take 1 tablet by mouth 3 times daily	☐ 1 Starter Pack	0
	☐ 550mg Tablets	☐ Take 1 tablet by mouth twice daily	☐ 60 Tablets	____

Prescriber's Signature (no stamp signature) If Brand required check ☐ DAW ________ Date

By signing this form, you are authorizing Martin's Specialty Pharmacy and its representatives to act as your prior authorization designated agent to work with prescription and medical insurance companies to initiate and execute the process.

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