UnityPoint at Home

SPECIALTY PHARMACY
Phone: 1 (877) 804-2713
Fax: 1 (855) 806-7285

GASTROENTEROLOGY PRESCRIPTION AND REFERRAL FORM

PATIENT INFORMATION

Please send a copy of ALL the patient's insurance cards including Prescription, Primary and Secondary (both sides) Also include any other beneficial information for prior authorization and dispensing assessments.

Patient Name _____ **DOB** _____ **Gender** ☐ Male ☐ Female

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work phone** _____ **Email** _____

Primary Language ☐ English ☐ Spanish ☐ Other specify_____ **Allergies** _____

RX Member ID _____ **RX Group ID** _____ **RX PCN** _____ **RX BIN**_____

PATIENT AUTHORIZATION OF PERSONAL INFORMATION DELIVERY

By providing your preferred method of contact, signing and dating below you the patient are granting UnityPoint at Home permission to leave a voicemail or send a confidential email with personal information regarding your prescription.

Preferred method of communication: ☐ Email _____ **OR** ☐ Phone _____

Patient Signature_____ Date_____

PRESCRIPTION INFORMATION

☐ **Cimzia®** (Certolizumab Pegol) ☐ 200mg Prefilled Syringes ☐ 200mg Lyophilized Vial ☐ Starter Kit
Sig: ☐ Inject 400mg sub-q ONCE at weeks 0, 2, and 4 Disp. 1 month supply No Refills
☐ Inject 400mg sub-q ONCE every FOUR weeks Disp. 1 month supply Refill: x_____

☐ **Humira®** (Adalimumab) ☐40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe ☐ 40mg/0.8ml Starter Pen Package
Sig: ☐ Inject 160mg sub-q on Day 1 **OR** ☐ Inject 80mg sub-q on Day 1 and Day 2 Disp. 1 month supply No Refills
Followed by 80mg sub-q on Day 15 and 40mg sub-q on Day 29
☐ Inject 40mg sub-q every OTHER week Disp. 1 month supply Refill: x_____

☐Other_____ Disp. 1 month supply Refill: x_____
☐ Injection training from My Humira® *Patient must sign*_____
For Ulcerative Colitis only continue treatment if clinical remission occurs by day 75.
For Crohn's patients, the use of adalimumab beyond one year has not been evaluated in clinical studies.

☐ **Simponi®** (Golimumab) ☐100mg SmartJect® ☐100mg Pre-filled Syringe
Sig: ☐ Inject 200mg sub-q at week 0, then 100mg sub-q at week 2 Disp. 1 month supply No Refills
☐ Inject 100mg sub-q every FOUR weeks Disp. 1 month supply Refill: x_____

☐ **Xifaxan®** (Rifaximin) ☐ 200mg tabs ☐ 550mg tabs
Sig: Take _____ tablets _____ time(s) per day Disp. 1 month supply Refill: x_____

☐ **OTHER**_____

Date:		**Signature:** (No Stamps)	

Prescriber authorization: By signing above I certify that the above therapy is medically necessary. I authorize this pharmacy to act as my authorized agent to secure coverage and initiate the insurance prior authorization 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 to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

PRESCRIBER INFORMATION

Print Prescriber's Name: _____ NPI: _____ Phone_____

Address _____City_____ State _____ Fax _____

CLINICAL INFORMATION

ICD-10 code _____ Description _____

Ht _____ Wt_____ SCr _____ Collection Date _____ TB skin test result _____ TB Skin test result date_____

Previous therapy _____