Gastroenterology Enrollment Form

SKYEMED PHARMACY & INFUSION SERVICES

Pharmacy Phone: 866-778-8255
Fax: 800-432-6614
pharmacy@skyemed.com

Deliver Medications To: ☐ Patient's Home ☐ Doctors Office Date Needed By: _____

Patient Demographics:

Last Name: First Name: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: SSN:

Prescription Insurance: (Please attach copy of the front and back of patient's card)

Primary Prescription Insurance: _____ RX BIN #: _____ RX PCN#: _____
Patient ID/Policy Number: _____ Patient RX Group Number: _____
Secondary Prescription Insurance: _____ RX BIN #: _____ RX PCN#: _____
Patient ID/Policy Number: _____ Patient RX Group Number: _____

Patient Clinical Information/History: (Please attach a copy of patient's recent chart notes, pathology and labs)

Diagnosis: _____ ICD10 Code: _____ Diagnosis Date: _____ Patient's weight (lbs): _____
Does patient have active/serious infection: Y N Severity: Moderate Severe Sex: M F Pregnant: Y N
Drug Allergies: _____ NKDA ☐
Current Medications including OTC products: _____
Previous/Failed Medications: Date and Duration of Therapy: Reason for Discontinuation:

Nursing Orders:

☐ Infusion Nursing: Nurse to administer drug therapy to patient ☐ Nursing Teach & Train Order ☐ Other: _____

Prescription Information:

Drug	Strength	Directions	Qty	Refill
Cimzia	☐ Starter Kit	*Induction Dose:* Inject 400mg SQ at Weeks 0, 2 and 4, then maintenance dose	1 kit	0
	☐ 200mg PFS ☐ 200mg LYO Vials	*Maintenance Dose:* Inject 400mg SQ every 4 weeks		
Simponi	☐ 100mg/ml Smartject ☐ 100mg/ml PFS	☐ *Induction Dose:* Inject 200mg SQ on week 0 and 100mg at Week 2, then maintenance dose	3	0
		☐ *Maintenance Dose:* Inject 100mg SQ every 4 weeks		
Humira	☐ Starter Pack	☐ *Induction Dose:* Inject 160mg SQ at Week 0, 80mg Day 15, 40mg Day 29, then maintenance dose	1 kit	0
	☐ 40mg Pen ☐ 40mg PFS	☐ *Maintenance Dose:* Inject 40mg SQ every other week ☐ *Other:* _____		
Remicade Wt: _____	100mg vial	☐ Infuse ___mg/kg IV at Weeks 0, 2, and 6, then ___mg/kg Q 8 weeks ☐ Other: _____	doses	
		☐ Epipen ___mg Use as Directed for adverse reaction		
Syprine	250mg Capsules	Take ____ capsules by mouth ____ times daily		
Xifaxan	550mg Tablets	Take 1 tablet by mouth 3 times daily for 14 days ICD10 K58.9	14 days	

Prescriber Information:

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: **Office Fax:** **Office Contact:**

DEA: NPI: TAXID: State License:

Physician Signature: _____ **Date:** _____

***If Physician requests brand name Only, "Brand Medically Necessary" Must be handwritten below:**