

# Gastroenterology Enrollment Form A-S

## TwelveStone Health Partners



Date: \_\_\_\_\_

**Fax Referral To: (800) 223-4063**

Patient Name: \_\_\_\_\_

**Direct Phone: (615) 278-3350**

Date of Birth: \_\_\_\_\_

**Toll Free: (844) 893-0012**

### INFORMATION

Ship To:	Injection Training Provided by:
<input type="checkbox"/> Patient <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> 1st Dose to Physician/Clinic, Remaining Refills to Patient	<input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Manufacturer <input type="checkbox"/> Other: _____

### DIAGNOSIS

**Description/ICD-10 Code:**

<input type="checkbox"/> A04.7 Enterocolitis due to Clostridium difficile	<input type="checkbox"/> K20.0 Eosinophilic esophagitis
<input type="checkbox"/> K50. ____ Crohn's disease	<input type="checkbox"/> K51. ____ Ulcerative colitis
<input type="checkbox"/> K58.0 Irritable Bowel Syndrome w/ Diarrhea	<input type="checkbox"/> K58.1 Irritable Bowel Syndrome w/ Constipation
<input type="checkbox"/> K72.9 Hepatic failure, unspecified (Hepatic Encephalopathy)	<input type="checkbox"/> Other: _____

### CLINICAL INFORMATION- (Please attach all clinical information, lab results, and other medical history documents)

Patient Demographics   
  Medical Card (front and back)   
  Prescription Card (front and back)   
  Clinic notes & labs (including Hepatitis B screening)

Last 4 Digits of Social: \_\_\_\_\_ TB Test Completed:  No  Yes    Date of negative test: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Please send copy of results)

Patient Weight: \_\_\_\_\_ kg/lbs    Height: \_\_\_\_\_ in/cm    Allergies: \_\_\_\_\_

<b>Currently Receiving and/or Prior Failed Therapies:</b>	<input type="checkbox"/> NSAIDS <input type="checkbox"/> Methotrexate <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> 5-ASA <input type="checkbox"/> Azathioprine	Contraindicated Medications:  Reason: _____
	<input type="checkbox"/> Corticosteroids <input type="checkbox"/> Mercaptopurine <input type="checkbox"/> Biologics: _____	
	<input type="checkbox"/> Other: _____	
	Length of Treatment: _____ Reason for Discontinuing or Adding Supplemental Tx: _____	

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> 200mg/ml PFS Starter Kit	Induction: Inject 400mg (two 200mg injections) SQ at weeks 0, 2 and 4, then maintenance dose	1 box (six 200mg PFS)	0
	<input type="checkbox"/> 200mg/ml PFS	Maintenance: Inject 400mg(two 200mg injections) SQ every 4 weeks	2	
	<input type="checkbox"/> 200mg LYO Powder Vial			
<input type="checkbox"/> DUPIXENT	<input type="checkbox"/> 300mg PFS	Inject 300mg SQ every week		
	<input type="checkbox"/> 300mg Pre-filled Pen			
<input type="checkbox"/> HUMIRA	<input type="checkbox"/> 80mg/0.8ml CF Pen Starter Kit for Crohn's/UC	Induction: Inject 160mg SQ on Day 1, 80mg on Day 15, then maintenance dose	1 box (three 80mg Pens)	0
	<input type="checkbox"/> 40mg/0.4ml CF Pens	Maintenance: Inject 40mg SQ every other week	2	
	<input type="checkbox"/> 40mg/0.4ml CF PFS	Other: _____		
<input type="checkbox"/> IBSRELA	<input type="checkbox"/> 50mg Tablet	Take 1 tablet by mouth twice daily before meals		
<input type="checkbox"/> RINVOQ	<input type="checkbox"/> 15mg Tablet	UC Induction: Take 45mg by mouth once daily for 8 weeks		
	<input type="checkbox"/> 30mg Tablet	Crohn's Induction: Take 45mg by mouth once daily for 12 weeks		
	<input type="checkbox"/> 45mg Tablet	Maintenance: Take _____ mg by mouth once daily		
<input type="checkbox"/> SIMPONI	<input type="checkbox"/> 100mg/ml SmartJect Autoinjector	Induction: Inject 200mg SQ at week 0, then 100mg at week 2, then maintenance dose	3	
	<input type="checkbox"/> 100mg/ml PFS	Maintenance: Inject 100mg SQ every 4 weeks	1	

**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Dispense as Written: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Substitution Allowed: \_\_\_\_\_ Date: \_\_\_\_\_

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.

**Gastroenterology  
Enrollment Form X - Z**

**TwelveStone Health Partners**



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	<input type="checkbox"/> Corticosteroids <input type="checkbox"/> Mercaptopurine <input type="checkbox"/> Biologics: _____	
	<input type="checkbox"/> Other: _____	
	Length of Treatment: _____ Reason for Discontinuing or Adding Supplemental Tx: _____	

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> XELJANZ	<input type="checkbox"/> 10mg Tablet	Induction: Take 10mg by mouth twice daily for 8 weeks		1
	<input type="checkbox"/> 5mg Tablet	Maintenance: Take 5mg by mouth twice daily		
<input type="checkbox"/> XELJANZ XR	<input type="checkbox"/> 22mg Tablet	Induction: Take 22mg by mouth once daily for 8 weeks		1
	<input type="checkbox"/> 11mg Tablet	Maintenance: Take 11mg by mouth once daily		
		Other: _____		
<input type="checkbox"/> ZEPOSIA	<input type="checkbox"/> 7 Day Starter Pack	Titration: Take 0.23mg by mouth daily on Days 1-4, take 0.46mg daily on Days 5-7, and 0.92mg daily thereafter		
	<input type="checkbox"/> 37 Day Starter Pack			
	<input type="checkbox"/> 0.92mg Capsule	Maintenance: Take 1 capsule (0.92mg) by mouth daily		
<input type="checkbox"/> ZYMFENTRA	<input type="checkbox"/> 120mg PFS	Following Infliximab IV induction regimen and starting at Week 10, inject 120mg SQ once every 2 weeks		
	<input type="checkbox"/> 120mg PFS with needle guard			
	<input type="checkbox"/> 120mg Pen			

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