Carepoint™ Gastroenterology Therapy Enrollment

A Pharmacy That Truly Cares

www.carepointrx.com
Fax: 855-237-9113 | Toll Free: 855-237-9112
E-Prescribe: NCPDP 1487330 | NPI 1598013864

PATIENT

PLEASE INCLUDE FACE SHEET & ALL INSURANCE CARDS

Name _____ DOB _____ Phone _____

Address _____ City, State _____ Zip _____

MEDICAL ASSESSMENT

DATE: _____ Height & Weight: _____ Allergies: _____

Crohn's Disease: ☐ K50.0 Small Intestine ☐ K50.1 Large Intestine ☐ K50.8 Both Intestines ☐ K50.9 Unspecified
Ulcerative Colitis: ☐ K51.0 Ulc. Pancolitis ☐ K51.2 Ulc. Procolitis ☐ K51.5 Left-sided Colitis ☐ K51.8 Other ☐ K51.9 Unspecified
TB/PPD Test Results: _____ **History of Cancer?** ☐ Yes ☐ No **Secondary infection?** _____
Current Medications: _____

Prior Therapies:	Reason for Discontinuation:	Appx. Start Date:	Appx. End Date:

PRESCRIPTION

			Quantity/Refills:
Cimzia®	☐ Starter Pack	Inject 400mg subcutaneously at week 0, week 2 and week 4	4 weeks / 0
	☐ Maintenance Pack	Inject 400mg subcutaneously once every 4 weeks	4 weeks / _____
Humira®	☐ Starter Pack *(Adult > 88 lbs.)*	☐ ***Adult:*** Inject 160mg subcutaneously on Day 1, 80mg on Day 15, then 40mg every other week for 4 weeks ☐ ***Child:*** Inject _____mg SC on Day 1, then _____mg on Day 15, then _____mg every other week for 4 weeks	4 weeks / 0
	☐ 40mg prefilled syringe ☐ 40mg vial	Inject 40mg SC once: ☐ WEEKLY ☐ EVERY OTHER WEEK	4 weeks / _____
Remicade®	☐ 100mg/20ml vial ☐ ***Please arrange home nursing***	☐ Infuse _____mg IV on week 0, week 2 and week 6 ☐ Infuse _____mg IV every 8 weeks	4 weeks / _____
Simponi®	☐ 100mg prefilled syringe	☐ Inject 200mg SC at week 0 and 100mg at week 2	4 weeks / 0
		☐ Inject 100mg SC at week 6, then every 4 weeks thereafter	4 weeks / _____
Xifaxan®	☐ 200mg ☐ 550mg tablets	☐ Sig: _____	4 weeks / _____
Other	☐ Methotrexate ☐ Sulfasalazine ☐ 6-Mercaptopurine ☐ _____	☐ Sig: _____ _____	_____ /_____

☒ Dispense sufficient quantity of all necessary supplies (syringes, needles, gloves, alcohol wipes, etc.) for proper medication administration

PROVIDER

PLEASE INCLUDE ALL RECENT LABS & CLINICAL NOTES

Prescriber Name _____ Phone _____ Fax _____

_____ (_____) _____

Prescriber Signature ***NPI or DEA*** ***In-Office Contact Person***

**By signing this form and utilizing our services, you authorize Carepoint and its employees to serve as your designated agent for handling prior authorizations and other medical and prescription insurance forms and communications*