Community Memorial Pharmacy
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Gastroenterology (A-G) Cimzia®, Dupixent®, Entyvio®

Prescriber Information

Prescriber Name _____ ☐ MD ☐ DO ☐ NP ☐ PA NPI _____

Office Contact _____ Practice Name / Collaborating MD _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name _____ Last 4 Digits of SS# _____ DOB / /

Sex ☐ M ☐ F Weight _____ Height _____ Diabetic? ☐ Y ☐ N

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell _____ HIPAA Contact _____

Emergency # _____

Interpreter Needed? ☐ Y ☐ N | Allergies ☐ Y ☐ N If Yes, list allergies _____

Insurance Information

Primary Insurance _____ Policy ID _____ Group# _____

BIN _____ PCN _____

Policyholder Name _____ Policyholder DOB / /

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

ICD-10/Diagnosis Code

Crohn's Disease ☐ K50.0 ____ (Crohn's of the Small Intestine) ☐ K50.1 ____ (Crohn's of the Large Intestine) ☐ K50.8 ____ (Crohn's of Both Intestines) ☐ K50.9 ____ (Crohn's, Unspecified)

Ulcerative Colitis ☐ K51.0 ____ (Ulcerative Pancolitis) ☐ K51.2 ____ (Ulcerative Procolitis)
☐ K51.3 ____ (Ulcerative Rectosigmoiditis) ☐ K51.5 ____ (Left Sided Colitis)
☐ K51.8 ____ (Other Ulcerative Colitis) ☐ K51.9 ____ (Ulcerative Colitis, Unspecified)
☐ K58.0 ____ (Irritable Bowel Syndrome with Diarrhea) ☐ Other _____

Date of Diagnosis / / Date of Negative TB Test / /

Prior Treatment? ☐ Y ☐ N (Provide Information Below)

Prior Therapy _____

Reason for Discontinuation of Therapy _____ Approx. Start Date / /
Approx. End Date / /

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **CIMZIA®** ☐ PFS	☐ Prefilled Syringe Starter Kit (6x200 mg/ml) ☐ 1 carton (2x200 mg/ml)	Starter Dose: ☐ Inject 400 mg SQ at weeks 0, 2 and 4 Maintenance Dose: ☐ Inject 400 mg SQ every 4 weeks ☐ Inject 200 mg SQ every 2 weeks	
☐ **DUPIXENT®** ☐ PFS ☐ Pen	☐ 2 cartons (4x300 mg/2ml)	☐ Inject 300 mg SQ once weekly	
☐ **ENTYVIO®**	☐ 2 cartons (2x108 mg/0.68 ml)	Maintenance Dose: ☐ Inject 108mg SQ once every 2 weeks	

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____ *Substitution Permitted*

Date _____

Prescriber Signature _____ *Dispense as Written*

Date _____

If brand is required, please write "DAW" in the box to the right. ☐