Gastroenterology Enrollment Form
Medford Chemists

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PATIENT INFORMATION

Name:	Date of Birth:		O Male O Female
Address:	City:	State:	Zip:
Phone:	Alt Phone:		Primary Language:
Emergency Contact, phone:	Email:		SS#:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Office Contact:			Fax:

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION/MEDICAL COVERAGE CARD, FRONT & BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

ICD-10 Code & Description: ____

Patient Evaluation: Height: ________________ in/cm (please indicate units) Weight: ________________ kg/lbs (please indicate units)

Allergies: ____

TB Test results:____________ Date: __________

Needs by Date: ____________ Ship to: ☐ Patient ☐ Office ☐ Other (provide address): ____________________

MEDICATION

HBV:
- ☐ Adefovir
- ☐ Baraclude ® (entecavir)
- ☐ Epivir ® (lamivudine)
- ☐ Vemlidy ®

OTHER:
- ☐ Xifaxan ® (C.diff)
- ☐ Eohilia ®R (EOE)
- ☐ Dupixent ® (EOE)
- ☐ Zorbtive ®

CROHN'S/COLITIS:
- ☐ Cimzia ®
- ☐ Entyvio ®
- ☐ Humira ® (and biosimilars)
- ☐ Rinvoq ®
- ☐ Remicade ®
- ☐ Renflexis ®
- ☐ Inflectra ®
- ☐ infliximab (unbranded)
- ☐ Simponi ®
- ☐ Skyrizi ®
- ☐ Xeljanz ®
- ☐ Zeposia ®
- ☐ Stelara ® (and biosimilars)
- ☐ Other: ______________

PRESCRIPTION INFORMATION

Dosage Form	Dose	Directions	Qty/Day Supply	Refills
	Initial Dose:		Qty____________ Day supply: ______	
	Maintenance Dose:		Qty____________ Day supply: ______	
	Other:		Qty____________ Day supply: ______	

INJECTION TRAINING

☐ Patient has received pen & injection training ☐ Physician's office to provide injection training ☐ Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

Prescribing Practitioner: The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing this form and utilizing our services, you are also authorizing Medford Chemists Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

☐ **DAW Brand Medically Necessary** ☐ **y Substitute/ Substitution Permissible**

Prescribing Practitioner Date

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