GASTROENTEROLOGY PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Owl Specialty Pharmacy
1010 E. Arrow Hwy., Covina, CA 91724
Phone: 626-209-8169 Fax: 626-209-8171 or 855-817-9523
www.owlspecialty.com

Patient Information: please provide a copy of the patient's insurance card or information

Patient Name:	DOB:	Gender: ☐ F ☐ M	HT:	WT:
Address:	City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's name:	ID#:	Group #:	

Allergies: ☐ NKDA ☐ List allergies:

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:

TB Test/Date:

Prior Therapies:

☐ **Patient is currently on therapy** (Start date ____/_____/_______)

Hepatic Encephalopathy / IBS-D / Traveler's Diarrhea

Medication	Strength	Directions	Quantity	Refills
☐ **Xifaxan®**	☐ 200 mg ☐ 550 mg	☐ Take one 200 mg tablet by mouth three times a day for 3 days ☐ Take one 550 mg tablet by mouth two times a day ☐ Take one 550 mg tablet by mouth three times a day for 14 days		

Crohn's Disease / Ulcerative Colitis

Medication	Strength	Directions	Quantity	Refills
☐ Dificid	☐ 200 mg tablet	☐ Take one tablet orally twice daily for 10 days with or without food		
☐ Humira® Citrate Free	☐ Starter Kit - 80mg / 0.8mL ☐ 40 mg/ 0.4 mL pens or prefilled syringes	☐ Inject 160 mg SC day 1; 80 mg day 15; two weeks later (Day 29), begin a maintenance dose of 40 mg every other week ☐ Inject 40 mg SC every other week		
☐ Entyvio®	☐ 300 mg/ 20 mL vial	☐ Infuse IV 300 mg weeks 0, 2, 6 ☐ Infuse IV 300 mg every 8 weeks		
☐ Relistor®	☐ 8 mg syringe (Pt's weight 38-61kg) ☐ 12 mg syringe (Pt's weight 62-114kg) ☐ Other _________mg ☐ 150 mg tablets	☐ Inject 1 syringe SC Once Daily ☐ Inject 1 syringe SC Once Daily ☐ Inject _______mg SC Once Daily ☐ Take 3 Tablets (450 mg total) by mouth once daily in the morning		
☐ Remicade®	☐ 100 mg/ 20 mL vial	☐ Infuse IV 5 mg/ kg weeks 0, 2, 6 ☐ Infuse IV 5 mg/ kg every 8 weeks ☐ Infuse IV		
☐ Rinvoq®	☐ 45 mg ER Tab ☐ 30 mg ER Tab ☐ 15 mg ER Tab	☐ 45 mg PO qd x 8 weeks ☐ 30 mg PO qd ☐ 15 mg PO qd		
☐ Simponi®	☐ 100 mg/ mL Smartject® Autojector ☐ 100 mg/ mL PFS	☐ Inject SC 200 mg week 0; 100 mg weeks 2, 6 ☐ Inject SC 100 mg every 4 weeks		
☐ Skyrizi®	☐ 600 mg Infusion ☐ 360 mg Auto- Inject device	☐ Infuse IV 600 mg on weeks 0, 4, 8 ☐ 360 mg SC every 8 weeks. Start 4 weeks after last induction dose.		
☐ Stelara®	☐ 90 mg/ mL PFS ☐ 130 mg/ 26 ml Infusion	☐ Inject SC 90 mg dose 8 weeks after the initial IV dose, then every 8 weeks **Date of initial IV dose: _______. Infuse _____mg IV for one dose.**		
☐ Xeljanz®	☐ 10 mg tablet ☐ XR 22 mg tablet	☐ Take 10 mg PO twice daily ☐ Other ☐ Take 22 mg PO once daily		
☐ Zinplava®	☐ 10 mg/kg IV	☐ Infuse 10 mg/kg IV over 60 minutes as a single dose		
☐ Other:				

Prescriber Information

Prescriber name:		Phone:	Office contact name:	
Prescriber address:	City:		State:	Zip:
NPI:	DEA:	Fax and/or Email:		
Prescriber signature:		Date:	☐ **DO NOT SUBSTITUTE**	

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