Medical Center PHARMACY
Service Delivery Trust Since 1924

Gastroenterology

Phone # 1-844-546-7577 • 619-263-1998
Fax # 1-844-240-2518 • 619-243-3245

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

☐ Deliver Here

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐ Male ☐ Female
Email : _____
Last 4# of SS: _____

PRESCRIBER INFORMATION

☐ Deliver Here

Name: _____
State License #: _____ NPI: _____
DEA #: _____ Tax ID _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION

If available, please fax copy of prescription insurance cards with this form (front and back).

MEDICAL INFORMATION

Prior Failed Medication(s):	Reason for Discontinuing	Length of Treatment
☐		____/____/____-____/____/____
☐		____/____/____-____/____/____
☐		____/____/____-____/____/____

☐ K50.90 Chron's Disease
☐ K51.90 Ulcerative Colitis
☐ K580 IBS, diarrhea-predominant
☐ Other:_____

Patient Clinical Assessment:

Height:_____ inch/ft Weight:_____ lb/kg

Allergies:_____

Has TB Test has been performed? ☐YES ☐NO Specific Date:_____

Hepatitis B ruled out or being treated:
☐ Yes ☐ No

PRESCRIPTION

Drug		Directions & Quantity	Refills
Cimzia	☐ Prefilled Syringe ☐ Lyophilized Powder	☐ **INITIAL:** Inject 400mg SQ on day 1, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200mg SQ every 2 weeks (Quantity: 2)	
Humira	☐ Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160mg SQ on day 1, then 80mg on day 14 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40mg SQ every other week (Quantity: 2)	
Remicade	☐ Vials	☐ **INITIAL**: Infuse _5mg/____kg=_____mg on day 0, 14, and 42 (Quantity: _____) ☐ **MAINTENANCE:** Infuse _____mg every 8 weeks (Quantity: _____)	
Simponi	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 200mg SQ on day 1, then 100mg on day 14 (Quantity: 3) ☐ **MAINTENANCE:** Inject 100mg SQ every 4 weeks (Quantity: 1)	
Entyvio	☐ 300mg in 20 mL Vial	☐ **INITIAL / MAINTENANCE** : Week zero two and six weeks, then every eight weeks thereafter	
Xifaxan	☐ 200mg ☐ 550mg	☐ Take 1 tablet 3 times daily for 14 days	
Uceris	☐ 9mg Tab	☐ Take 1 tablet by mouth qam with or without food	
Viberzi	☐ 75mg ☐ 100mg	☐ Take orally twice daily with food ☐ Take orally twice daily with food	
Other			

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Pharmacy to coordinate injection training or infusion

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: **Date:**

Dispense as written **Date** **Substitution Premissable** **Date**

I authorize Medical Center Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions:_____

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289
3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102

ACCREDITED SPECIALTY PHARMACY urac ACCREDITED SPECIALTY PHARMACY