To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: ______________________________

Email: ______________________________

Direct Phone Line: ______________________________

Cell (optional, but preferred): ______________________________

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Gastrointestinal Enrollment Form A - H

Prescriber:		**NPI:**
Supervising Physician:		**NPI:**
Address:		**Tax ID:**
Phone:	Fax:	
Contact:		

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/________	SS#: _____-_____-_________
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: ________	Wt.: ________ Ht.: ________

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐**Yes Start Date:** ____/____/______ ☐**No** **SHIP TO:** ☐**Patient's Home** ☐**Doctor's Office** ☐**Other:** ___________

Drug		Directions & Quantity	Refills
Cimzia®	☐ 200 mg Pre-filled Syringe ☐ 200 mg Vial	☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2)	
Dupixent®	☐ 300 mg Pre-filled Syringe ☐ 300 mg Pen	☐ Inject 300 mg SQ every week (Quantity: 4) *****WEIGHT REQUIRED***** _____ *****Intended for ages 12 and older with weight ≥ 40 kg/88 lbs*****	
Entyvio®	☐ 300 mg Vial	☐ **INITIAL:** Infuse 300 mg IV over 30 minutes at Day 0, 14, and 42 (Quantity: 3) ☐ **MAINTENANCE:** Infuse 300 mg IV over 30 minutes every 8 weeks (Quantity: 1)	
Humira® ***Citrate Free***	☐ 80 mg/0.8 mL Crohn's/UC Starter Kit ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ 80 mg/0.8 mL Crohn's Starter Kit	**PEDIATRIC:** *****WEIGHT REQUIRED***** ______ ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 15, then 20 mg every **other** week starting on day 29 (Quantity: 2)	
	☐ 20 mg/0.2 mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) *****Intended for weight 17 kg/37 lbs to <40 kg/88 lbs*****	
	☐ 80 mg/0.8 mL Crohn's Starter Kit ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) *****Intended for weight ≥40 kg/88 lbs*****	
	☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	**PEDIATRIC:** *****WEIGHT REQUIRED***** ______ ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, 40 mg on day 15 (Quantity: 4) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week starting on day 29 (Quantity: 2) *****Intended for weight 20 kg/44 lbs to <40 kg/88 lbs*****	
	☐ 20 mg/0.2 mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 20 mg SQ every week starting on day 29 (Quantity: 4)	
	☐ 80 mg/0.8 mL Pediatric UC Starter Kit ☐ 80 mg/0.8 mL Pen ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 8, 80 mg on day 15 (Quantity: 4) ☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week starting on day 29 (Quantity: 2) *****Intended for weight ≥40 kg/88 lbs***** ☐ **MAINTENANCE:** Inject 40 mg SQ every week starting on day 29 (Quantity: 4)	

MEDICAL INFORMATION

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

PREVIOUS THERAPIES:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Methotrexate	☐ (________________)	☐	____________________
☐ Sulfasalazine	☐ (________________)	☐	____________________
☐ Pentasa	☐ (________________)	☐	____________________
☐ Cimzia	☐ (________________)	☐	____________________
☐ Humira	☐ (________________)	☐	____________________
☐ ________________	☐ (________________)	☐	____________________
☐ ________________	☐ (________________)	☐	____________________

- ☐ K20.0 Eosinophilic Esophagitis
- ☐ K20. ___ ________________________________
- ☐ K50.00 Crohn's disease of small intestine, without complications
- ☐ K50.10 Crohn's disease of large intestine, without complications
- ☐ K50.80 Crohn's disease of both intestines, without complications
- ☐ K50.90 Crohn's disease unspecified, without complications
- ☐ K51.50 Left-sided Ulcerative Colitis, without complications
- ☐ K51.80 Other Ulcerative Colitis, without complications
- ☐ K51.90 Ulcerative Colitis unspecified, without complications
- ☐ Other: ____

Date of Diagnosis: ____/____/________ **Allergies:**____

Active TB is ruled out: ☐Yes ☐No Date: ____/____/________ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/________

☐Patient is steroid dependent

Additional Clinical Information:

INJECTION TRAINING

☐Patient has received pen and injection training ☐ Physician's office to provide injection training ☐Genefic to coordinate injection training

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Genefic Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber:	**Date**: ______/______/__________

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender if you have received this document in error and then destroy this document immediately.