GASTROENTEROLOGY

Spring Creek Pharmacy

Phone: 972-517-7900
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280 Legacy Drive #102 Plano,TX 75023

DATE _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFORMATION

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFORMATION

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis Code: ❑ 555.0 Crohn's Disease ❑ 556.9 Ulcerative Colitis ❑ 070.54 Chronic Hepatitis C ❑ 572.2 Hepatic Encephalopathy

Genotype: ❑ 1 ❑ 1a ❑ 1b ❑ 2 ❑ 2a ❑ 2b ❑ 3a ❑ 3b ❑ 4 Viral Load: _____ IU/ml Viral Load Date: _____

History: • Has the Patient been treated previously for this condition? ❑ Yes ❑ No

❑ NSAIDS	Duration _____	❑ Sulfasalazine	Duration _____	❑ Corticosteroid	Duration _____
❑ MTX	Duration _____	❑ 5-ASA (5-Aminosalicylates)	Duration _____	❑ 6-MP (6-Mercaptopurine)	Duration _____
❑ Biologics	Duration _____	❑ Azathioprine	Duration _____	❑ Other	Duration _____

❑ Treatment Naive ❑ Previously Treated: Prior treatment used: _____ ❑ Non-Responder ❑ Responder/Relasper

Duration of previous therapy: From _____ to _____ Total of: _____ months HIV Coinfected: ❑ Yes ❑ No HBV Coinfected: ❑ Yes ❑ No

Compensated Liver Disease: ❑ Yes ❑ No Cirrhosis: ❑ Yes ❑ No Metavir Score: _____ Solid Organ Transplant Recipient: ❑ Yes ❑ No Awaiting Liver Transplant: ❑ Yes ❑ No

- Is the patient currently on any therapy? ❑ Yes ❑ No List Meds: _____
- Will patient stop taking Meds before starting the new med? ❑ Yes ❑ No • How long will the patient wait before starting the new med? _____
- Other meds patient is on? _____
- Has patient received PPD (skin test)? ❑ Yes ❑ No • Results: _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Harvoni®	❑ 90mg/400mg Tablet	❑ Take 1 tablet by mouth daily with or without food	28 Day Supply	_____
❑ Sovaldi®	❑ 400mg Tablet	❑ Take 1 tablet by mouth once per day	28 Day Supply	_____
❑ Olysio®	❑ 150mg Capsule	❑ Take 1 capsule by mouth once per day with food	28 Day Supply	_____
❑ Viekira-Pak®	❑ 12.5mg/75mg/ 50mg/250mg Tablets	❑ 3 tablets 9:00AM and 1 tablet 9:00PM with meal	28 Day Supply	_____
❑ Incivek®	❑ 375mg Capsule	❑ Take 2 capsules (750mg) TLD	28 Day Supply	_____
❑ Cimzia®	❑ 200x2 Prefilled Syringe ❑ 200x2 LYO Powder	❑ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 ❑ Inject 400mg subcutaneously once every 4 weeks	4 Week Supply	_____
❑ Humira®	❑ Crohn's Starter Kit ❑ 40mg Pen ❑ 40mg Prefilled Syringe	❑ Inject 160mg ❑ Four 40mg SubQ day 1 OR ❑ Two 40mg SubQ days 1 & 2 then Week 2 Inject 80mg (Two 40mg injections) subcutaneously on day 15 ❑ Week 4+: Inject 40mg subcutaneously every other week _____	Loading Dose 4 Week Supply	None _____
❑ Remicade® Wt: _____	❑ 100mg Vial	❑ Infuse _____mg IV on week 0, week 2, week 6, then ❑ Infuse _____mg IV every _____ weeks for _____ infusions	Loading Dose 4 Week Supply	None _____
❑ Simponi® UC	❑ 100mg SmartJect ❑ 100mg Prefilled Syringe	❑ Inject 200mg SubQ at week 0, then 100mg at week 2, 100mg every 4 weeks ❑ Inject 100mg subcutaneously once every 4 weeks	Loading Dose 4 Week Supply	None _____

Prescriber's Signature (no stamps) **If Brand required check ❑ DAW** **Date**

By signing this form and utilizing our services, you are authorizing Blake Pharmacy and it's emplyees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.