MID-WEST SPECIALTY PHARMACY

PHONE: (888)544-1111 FAX:(424)777-0888

Gastroenterology Prior Authorization Form

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______

Address ______

Address 2 ______

City, State, ZIP ______

Home Phone ______ Alternate Phone ______

DOB ______ Last Four of SS# ______ Gender ______

Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______

DEA ______

NPI ______

Group/Hospital ______

Address ______

City, State, ZIP ______

Phone ______ Fax ______

Contact Person ______ Phone ______

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number ______

MEDICAL INFORMATION (Section must be completed to process prescription) *(Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications

☐ K50.10 Crohn's disease of large intestine without complications

☐ K50.90 Crohn's disease, unspecified, without complications

☐ Other Diagnosis: ICD-10 Code ______ Description ______

Date of Diagnosis ______

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg/lbs Height ______ cm/in

Allergies ______

Lab Data ______

Prior Therapies ______

Concomitant Medications ______

Additional Comments ______

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Stelara® ☐ Enroll in CarePath®	☐ 130mg/26ml solution single dose vial ☐ Maintenance: Inject 90mg/ml prefilled syringe 8 weeks following initial dose and every 8 weeks thereafter	Initiation Dose - Infuse ☐ 260mg ☐ 390mg ☐ 520mg as initial intravenous dose as directed by prescriber ☐ Inject 90mg prefilled syringe 8 weeks following initial dose and every 8 weeks thereafter		
☐ Cimzia® (UCB) ☐ Enroll in CIMplicity®	☐ 200mg/ml Vial Kit ☐ 200mg/ml Starter Kit ☐ 200mg/ml single use Prefilled Syringe	☐ Initiation Dose - Inject 400mg subcutaneously at weeks zero, two and four ☐ Maintenance Dose - Inject 400mg subcutaneously every four weeks		
☐ Humira® (Abbvie) ☐ Enroll in Humira Complete	☐ 40mg/0.8ml Prefilled Autopen ☐ 20mg/0.8ml Prefilled Syringe ☐ 40mg/0.8ml Prefilled Syringe ☐ 40mg/0.8ml Pen Crohn's Starter Kit	☐ Initiation Dose - Inject 160mg (4pens) on day 1 followed by 80mg (2pens) on day 15 and 1 pen on Day 29 ☐ Maintenance Dose - Inject 40mg (1pen) subcutaneously every other week.		
☐ Simponi® ☐ Enroll in CarePath®	☐ 100mg/1ml in a single prefilled SmartJect® autoinjector ☐ 100mg/1ml in a single dose prefilled syringe	☐ Initiation Dose - Inject 200mg (2pens) subcutaneously at week zero followed by 100mg (1pen) at week two. ☐ Maintenance Dose - Inject 100mg subcutaneously every four weeks		
☐ Entyvio® ☐ Enroll in Entyvio Connect	☐ 300mg Single Use Vial	☐ Initiation Dose - Infuse 300mg intravenously over 30 minutes at weeks zero, two and six. ☐ Maintenance Dose - Infuse 300mg intravenously over 30 minutes every eight weeks		
☐ Remicade® (Janssen) ☐ Enroll in CarePath®	☐ 100mg/20ml Vial	☐ Initiation Dose - Infuse 5mg/kg at weeks zero, two and six. ☐ Maintenance Dose - Infuse 5mg/kg every eight weeks.		

Ship to: ☐ Patient ☐ Office ☐ Other ______ Date ______ Needs by Date ______

Statement of medical necessity: I certify the prescribed therapy is medically necessary. I will be supervising the patient treatment accordingly and all information is accurate to the best of my knowledge. I authorized Mid-West Pharmacy as my designated agent on behalf of my patient to (1) Provide any information on this form to the insurer of the above name patient and to (2) forward the above prescription by fax or other mode of delivery to the pharmacy chosen by the above name patient.

Prescriber Signature ______ **Date** ______

Important notice: This fax is intended to be delivered only to the named addressee. It contains materials that is confidential, privileged, proprietry or exempt from disclosure under applicable law.