Star Discount Pharmacy
specialty care

Gastroenterology Infusion

Call: (877) 883-1392 Fax: (256) 919-0000

Patient Information: Name:______________________ DOB:__________ Gender: ◯M ◯F

Address: ____________________________________ City: _________________ State: ____ Zip: _________

Phone: ____________________ Alt. Phone: __________ Email: ______________________ Ht: _____ Wt: _____

Care Giver: ____________________ Allergies: ◯ No Known ◯ See Attached Charts Other: ____________________

Please include front and back copies of insurance card

Prescriber Information

Name: ________________________ NPI: ____________ Phone: ______________ Fax: ______________

Address: __________________________ City: ____________ State:____ Zip:_________ Office Contact: __________

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: ____________________

◯ Crohn's Disease ◯Ulcerative Colitis ◯Irritable Bowel Syndrome

ICD-10:______________ Other:________________

Serious or active infection present? ◯Yes ◯No

Hep B ruled out or treatment started? ◯Yes ◯No

TB Test: ◯Positive ◯Negative Date: ________________

Site of Infusion:

◯MD's Office ◯Hospital Outpatient Clinic

◯Infusion Center ◯Patient Home ◯Other: ___________

Prior Failed Treatments	Drug Name & Length of Treatment
◯ 5-ASA	
◯ Biologics	
◯ Corticosteroids	
◯ Immunosuppressants	
◯ Methotrexate	
◯ Surgery	
◯ Other	

Infusion Site Information: (Required if Different from Prescriber)

Name: ________________________ Address: ______________________________ City: ______________

State: ______ Zip:__________ NPI: ________________ Phone: ________________ Fax: ______________

Medication	Dosage & Strength	Directions	Qty	Ref
◯ Entyvio	◯ 300mg/20ml Vial	**Induction Dose:**		
		◯Week 0: Infusion 300mg IV	1	0
		◯Week 2: Infusion 300mg IV	1	0
		◯Week 6: Infusion 300mg IV	1	0
		Maintenance Dose: ◯300mg IV 8 weeks after the last IV dose, then every 8 weeks thereafter	1	
◯Remicade	◯100mg/20ml Vial	**Induction Dose:** (adult and pediatric patients) ◯Week 0: Infusion 5mg/kg IV ◯Week 2: Infusion 5mg/kg IV ◯Week 6: Infusion 5mg/kg IV		
		Maintenance Dose: ◯5mg/kg IV 8 weeks after the last IV dose, then every 8 weeks thereafter ◯__________________ (dose can be increased to 10mg/kg if patient loses response to medication later on)		
◯Stelara	◯130mg/26ml Vial ◯45mg/0.5ml Prefilled Syringe ◯90mg/ml Prefilled Syringe ◯45mg/0.5ml Vial	**Induction Dose:**		
		◯Patient Weight <55kg: 260mg IV	2	0
		◯Patient Weight >55kg to 85kg: 390mg IV	3	0
		◯Patient Weight >85kg: 520mg IV	4	0
		Maintenance Dose: ◯Inject 90mg SC 8 weeks after the initial IV dose, then every 8 weeks thereafter		
◯	◯	◯		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: ______________________ Signature______________________ Date: __________

Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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