

GASTROENTEROLOGY ENROLLMENT FORM

EMAIL: INFO@BRIGENT.COM
FAX: 818-963-7526
PHONE: 818-963-7525

Brigent Specialty Pharmacy
4766 Park Granada Suite 112,
Calabasas, CA 91302
NPI: 1588300545



Ship to: Patient Physician Other

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: Female Male
 Address: _____ City/State/Zip: _____
 SSN: _____ Allergies: _____
 Phone: _____ Alt Phone: _____
 Email: _____ Preferred Contact: Phone Email
 Parent/Caregiver/Legal Guardian Name (Last, First): _____
 Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION: Please fax copy of prescription and insurance cards with this form (front and back)

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Dx: _____
 B18.1 Hepatitis B A09 Traveler's Diarrhea
 K50.90 Crohn's Disease K58.0 IBS w/Diarrhea
 K76.82 Hepatic Encephalopathy K20.0 Eosinophilic Esophagitis
 K51.90 Ulcerative Colitis Other Code: _____ Description: _____
 Weight: _____ lb/kg Height: _____ in/cm **Treatment status:** New to therapy Continuation of
 TB Result: _____ Date: _____ therapy date of last treatment ____/____/____
 Needs by: ____/____/____

Tried and Failed History:

Medication: _____ Duration: _____
 Response: Intolerant Ineffective Contraindicated Side Effects Other: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Starter Kit 200mg <input type="checkbox"/> 200mg/ml PFS	<input type="checkbox"/> Initial Dose: Inject 400mg SQ once, then repeat at week 2 and 4 <input type="checkbox"/> Maintenance: Inject 400mg SQ every 4 weeks	6 PFS 2 PFS	None ____
<input type="checkbox"/> Dupixent (12+ years old, ≥ 40kg)	<input type="checkbox"/> 300mg/2ml Prefilled Pen <input type="checkbox"/> 300mg/2ml PFS	<input type="checkbox"/> Inject 300mg SQ every week	4	____
<input type="checkbox"/> Humira	<input type="checkbox"/> Citrate Free Crohn's/UC Starter Pack (80mg/0.8ml x3pens) <input type="checkbox"/> Citrate Free 40mg/0.4ml Pen <input type="checkbox"/> Citrate Free 40mg/0.4ml PFS	<input type="checkbox"/> Initial Dose: Inject 160mg SQ on day 1, then 80mg on day 15 <input type="checkbox"/> Maintenance: Inject 40mg SQ every other week starting day 29 <input type="checkbox"/> Other _____	3 2	None ____ ____
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg ER Tablet <input type="checkbox"/> 30mg ER Tablet <input type="checkbox"/> 45mg ER Tablet	<input type="checkbox"/> Initial Dose (UC): Take 45mg by mouth daily x8 weeks <input type="checkbox"/> Initial Dose (CD): Take 45mg by mouth daily x 12 weeks <input type="checkbox"/> Maintenance: Take 15mg PO QD <input type="checkbox"/> Other _____	28 28 30 ____	1 2 ____ ____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100mg/ml autoinjector <input type="checkbox"/> 100mg/ml PFS	<input type="checkbox"/> Initial Dose: Inject 200mg SQ at week 0, then 100mg at week 2 <input type="checkbox"/> Maintenance: Inject 100mg SQ every 4 weeks starting on week 6	3 1	None ____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 600mg/10ml Vial <input type="checkbox"/> 360mg/2.4ml Prefilled Cartridge	<input type="checkbox"/> Initial Dose: 600mg IV at week 1, 4, 8 <input type="checkbox"/> Maintenance Dose: 360mg SQ every 8 weeks starting at week 12	3 vials 1	None ___
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg/25mg SDV <input type="checkbox"/> 90mg/ml PFS	Initial Dose: <input type="checkbox"/> ≤ 55kg: 260mg (2 vials) IV as single dose <input type="checkbox"/> 55kg to 85kg: 390mg (3 vials) IV as a single dose <input type="checkbox"/> > 85kg: 520mg (4 vials) IV as a single dose <input type="checkbox"/> Maintenance: Inject 90mg SQ every 8 weeks; begin maintenance dose 8 weeks after the IV induction dose	2 vials 3 vials 4 vials 1 PFS	None None None ___
<input type="checkbox"/> Vemlidy	<input type="checkbox"/> 25mg	<input type="checkbox"/> Take 1 tablet by mouth once daily with food	30 tabs	___
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet	<input type="checkbox"/> Initial Dose: 10mg PO BID x 8weeks or _____ weeks <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Take 5mg by mouth twice daily <input type="checkbox"/> Take 10mg by mouth twice daily	___ 60 tabs	___ ___
<input type="checkbox"/> Xifaxan	<input type="checkbox"/> 200mg <input type="checkbox"/> 550mg	<input type="checkbox"/> Traveler's Diarrhea: Take 200mg PO TID x3 days	9 tabs	None
		<input type="checkbox"/> Hepatic Encephalopathy: Take 550mg PO BID	60 tabs	___
		<input type="checkbox"/> IBS w/Diarrhea: Take 550mg PO TID x14 days	42 tabs	None
		<input type="checkbox"/> Other: _____	___	___
<input type="checkbox"/> Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____	___	___

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
 Address: _____
 City: _____ Zip: _____ Phone: _____ Fax: _____
 Contact Person: _____ Contact Phone: _____

PRESCRIBER SIGNATURE (DO NOT STAMP) *NY & IA prescriptions must be submitted via e-script*

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature: _____
Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____
Date: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Brigent Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA requests as my signature.