GASTROENTEROLOGY ENROLLMENT FORM

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

IVI Pharmacy Inc dba
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
☐ K50.90 Crohn's Disease
☐ K76.82 Hepatic Encephalopathy
☐ K51.90 Ulcerative Colitis
☐ A09 Traveler's Diarrhea
☐ K58.0 IBS w/Diarrhea
☐ K20.0 Eosinophilic Esophagitis
☐ Other Code: _____ Description: _____

Weight: _____ lb/kg Height: _____ in/cm
TB Result: _____ Date: _____

Treatment status: ☐ New to therapy ☐ Continuation of 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
☐ Cimzia	☐ Starter Kit 200mg ☐ 200mg/ml PFS	☐ **Initial Dose:** Inject 400mg SQ once, then repeat at week 2 and 4 ☐ **Maintenance**: Inject 400mg SQ every 4 weeks	6 PFS 2 PFS	None ____
☐ Dupixent *(12+ years old, ≥ 40kg)*	☐ 300mg/2ml Prefilled Pen ☐ 300mg/2ml PFS	☐ Inject 300mg SQ every week	4	____
☐ Humira	☐ Citrate Free Crohn's/UC Starter Pack (80mg/0.8ml x3pens) ☐ Citrate Free 40mg/0.4ml Pen ☐ Citrate Free 40mg/0.4ml PFS	☐ **Initial Dose:** Inject 160mg SQ on day 1, then 80mg on day 15 ☐ **Maintenance:** Inject 40mg SQ every other week starting day 29 ☐ Other _____	3 2 ____	None ____ ____
☐ Rinvoq	☐ 15mg ER Tablet ☐ 30mg ER Tablet ☐ 45mg ER Tablet	☐ **Initial Dose (UC):** Take 45mg by mouth daily x8 weeks ☐ **Initial Dose (CD):** Take 45mg by mouth daily x 12 weeks ☐ **Maintenance:** Take 15mg PO QD ☐ Other_____	28 28 30 ____	1 2 ____ ____
☐ Simponi	☐ 100mg/ml autoinjector ☐ 100mg/ml PFS	☐ **Initial Dose:** Inject 200mg SQ at week 0, then 100mg at week 2 ☐ **Maintenance:** Inject 100mg SQ every 4 weeks starting on week 6	3 1	None ____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
☐ Skyrizi	☐ 600mg/10ml Vial ☐ 360mg/2.4ml Prefilled Cartridge	☐ **Initial Dose:** 600mg IV at week 1, 4, 8 ☐ **Maintenance Dose:** 360mg SQ every 8 weeks starting at week 12	3 vials 1	None ____
☐ Stelara	☐ 130mg/25mg SDV ☐ 90mg/ml PFS	**Initial Dose:** ☐ **≤ 55kg:** 260mg (2 vials) IV as single dose ☐ **55kg to 85kg:** 390mg (3 vials) IV as a single dose ☐ **> 85kg:** 520mg (4 vials) IV as a single dose ☐ **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 ____
☐ Vemlidy	☐ 25mg	☐ Take 1 tablet by mouth once daily with food	30 tabs	_____
☐ Xeljanz	☐ 5mg tablet ☐ 10mg tablet	☐ **Initial Dose:** 10mg PO BID x 8weeks or _____ weeks ☐ **Maintenance Dose:** ☐ Take5mg by mouth twice daily ☐ Take 10mg by mouth twice daily	____ 60 tabs	____ ____
☐ Xifaxan	☐ 200mg ☐ 550mg	☐ **Traveler's Diarrhea:** Take 200mg PO TID x3 days	9 tabs	None
		☐ **Hepatic Encephalopathy:** Take 550mg PO BID	60 tabs	_____
		☐ **IBS w/Diarrhea:** Take 550mg PO TID x14 days	42 tabs	None
		☐ Other: _____	____	____
☐ Other	☐ _____	☐ _____	____	____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Phone: _____ Fax: _____

Contact Person: _____ Contact Phone: _____

PRESCRIBER SIGNATURE (DO NOT STAMP)

"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.