



ACCREDITED  
Specialty Pharmacy  
Expires 07/01/2021



# FountainRx

2825 W. A.J. Hwy. Morristown, TN 37814

Phone: 423-307-5757

Toll Free: 844-990-9993

Please fax support documentation with RX to:

**423-307-5241**

## Gastroenterology

### Patient Information:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Gender: M F Caregiver: \_\_\_\_\_

### Prescriber Information:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
Tax ID: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### CLINICAL INFORMATION:

Diagnosis:  K50.90 Crohn's Disease  K51.90 Ulcerative Colitis  Other (ICD-10 Code): \_\_\_\_\_

### Drug Allergies:

Latex Allergy? Yes No TB/PPD Test given? Yes No (Please send copy of results)

### Prior Failed Medications:

<input type="checkbox"/> Methotrexate	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> Corticosteroids	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> Azathioprine	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> 5-ASA (Mesalamine)	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> Sulfasalazine:	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> Purinethol / 6-MP	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> Other: _____	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> Other: _____	Length of Treatment: _____	Reason for Discontinuing: _____

PLEASE FAX COPIES:  Medical Card (Front and Back)  Prescription Card (Front and Back)  Clinical Notes

INJECTION TRAINING:  Trained in Provider Office  Manufacturer Support  Trained by Pharmacist

Medication	Dosage and Strength	Directions	Quantity	Refills
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit 200mg/ml <input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg x LYO Powder	<input type="checkbox"/> <b>Starting (Starter Kit) Dose:</b> Inject 400mg SC on week 0, 2 and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 400mg SC every 4 weeks	6 2	None _____
<input type="checkbox"/> Entyvio™	<input type="checkbox"/> 300mg Vials	<input type="checkbox"/> <b>Starting Dose:</b> Infuse 300mg IV over 30 minutes at day 0, day 14, and day 42 <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse 300mg IV over 30 minutes every 8 weeks	3 1	None _____
<input type="checkbox"/> Humira®	<input type="checkbox"/> Crohn's Starter Kit (6 Pens) <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe	<input type="checkbox"/> <b>Starter Kit:</b> Inject 160mg (4-40mg) SC on day 1, then 80mg (2-40mg) on day 15 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 40mg SC every other week <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 40mg SC once a week <input type="checkbox"/> Patient has signed Humira® Complete Form	6 2 4	None _____ _____
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100mg Vials	<input type="checkbox"/> <b>Starting Dose:</b> Infuse: _____mg on day 0, day 14, and day 42 <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse: _____mg every 8 weeks	_____ _____	None _____
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100mg/ml Smartject Autoinjector <input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> <b>Starting Dose:</b> Inject 200mg SC at week 0, then 100mg on week 2 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 100mg SC every 4 weeks	3 1	None _____
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 130mg Vials <input type="checkbox"/> Up to 55kg <input type="checkbox"/> >55kg to 85kg <input type="checkbox"/> >85kg <input type="checkbox"/> 90mg Prefilled Syringe	<input type="checkbox"/> <b>Starting Dose:</b> Infuse: 260mg (2 vials) IV as a single dose at week 0 Infuse: 390mg (3 vials) IV as a single dose at week 0 Infuse: 520mg (4 vials) IV as a single dose at week 0 <input type="checkbox"/> <b>Maintenance: Dose</b> Inject 90mg SC 8 weeks after initial infusion then every 8 weeks thereafter	2 3 4 1	None None None _____
<input type="checkbox"/> Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

By signing this form and utilizing our services, you are authorizing Fountain Plaza Pharmacy, LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_