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Phone: 423-307-5757
6900 Lenox Village Dr., Ste #14 Nashville, TN 37211
Phone: 615-864-8990

FountainRx

Gastroenterology

Please fax patient demographics with prescription order form to:

Toll-Free 1-844-621-5199

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:

- ☐ **Methotrexate** Length of Treatment:__________Reason for Discontinuing:______________
- ☐ **Corticosteroids** Length of Treatment:__________Reason for Discontinuing:______________
- ☐ **Azathioprine** Length of Treatment:__________Reason for Discontinuing:______________
- ☐ **5-ASA (Mesalamine)** Length of Treatment:__________Reason for Discontinuing:______________
- ☐ **Sulfasalazine:** Length of Treatment:__________Reason for Discontinuing:______________
- ☐ **Purinethol / 6-MP** Length of Treatment:__________Reason for Discontinuing:______________
- ☐ **Other:**______________Length of Treatment:__________Reason for Discontinuing:______________
- ☐ **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
☐ **Cimzia®**	☐ Starter Kit 200mg/ml ☐ 200mg/ml Prefilled Syringe	☐ **Starting (Starter Kit) Dose**: Inject 400mg SC on week 0, 2 and 4 ☐ **Maintenance Dose:** Inject 400mg SC every 4 weeks	6 2	None
☐ **Entyvio™**	☐ 300mg Vials	☐ **Starting Dose:** Infuse 300mg IV over 30 minutes at day 0, day 14, and day 42 ☐ **Maintenance Dose:** Infuse 300mg IV over 30 minutes every 8 weeks	3 1	None
☐ **Humira®**	☐ Crohn's Starter Kit (3 Pens) CF ☐ 40mg/0.4ml Pen CF ☐ 40mg/0.4ml Prefilled Syringe CF	☐ **Starter Kit:** Inject 160mg (2-80mg) SC on day 1, then 80mg on day 15 ☐ **Maintenance Dose:** Inject 40mg SC every other week ☐ **Maintenance Dose:** Inject 40mg SC once a week	3 2 4	None
☐ **Remicade®**	☐ 100mg Vials	☐ **Starting Dose:** Infuse: ____________mg on day 0, day 14, and day 42 ☐ **Maintenance Dose:** Infuse: __________mg every 8 weeks		None
☐ **Simponi®**	☐ 100mg/ml Smartject Autoinjector ☐ 100mg/ml Prefilled Syringe	☐ **Starting Dose:** Inject 200mg SC at week 0, then 100mg on week 2 ☐ **Maintenance Dose:** Inject 100mg SC every 4 weeks	3 1	None
☐ **Stelara®**	☐ 130mg Vials ☐ Up to 55kg ☐ >55kg to 85kg ☐ >85kg ☐ 90mg Prefilled Syringe	☐ **Starting Dose:** 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 ☐ **Maintenance: Dose** Inject 90mg SC 8 weeks after initial infusion then every 8 weeks thereafter	2 3 4 1	None None None
☐ **Other**				

By signing this form and utilizing our services, you are authorizing FountainRx 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:**______________________