GASTROENTEROLOGY

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:	Circle one: M F	D.O.B.
Home Address:	City:	State:	Zip:
Height:	Weight:	Allergies:	
Preferred Method of Contact: ☐ Email ☐ Phone (Home):	Phone (Cell):	Phone (Work):	
Email: _____ Last 4 of SSN #: _____	Primary Language _____		

Insurance

Primary Insurance: **Complete and Attach Copies of card*	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	
Employer:	Prescription Card:	City:	State:	Phone:

Medical Necessity

Statement of Medical Necessity Date:

☐ 070.54 Chronic Hepatitis C ☐ 555.1 Crohns Large Intestine ☐ 555.9 Crohns unspecified ☐ 070.51 Acute Hepatitis C ☐ 555 Regional Enteritis

☐ 555.2 Crohns Large & Small Intestine ☐ 556 Ulcerative Colitis ☐ Other:_____

Injection Training/Home Health Coordination

Specialty Pharmacy to coordinate injection training/home health nurse as necessary ____Yes ____No *Agency of choice: _____

Reason: ☐ MD office trained patient ☐ Patient already independent ☐ Referred by MD office to alternate trainer

Prescription

HEPATITIS C

PEGASYS ®
☐ 180 ug/0.5 ml ProClick Autoinjector ☐ 135 ug/0.5 ml ProClick Autoinjector
☐ 180ug/0.5ml Prefilled Syringe Pac ☐ 180ug/1ml Vial

Directions: ☐ Inject 180ug subcutaneously Qweek as directed
☐ Other: _____

Quantity: _____ Refills: _____

PEG INTRON ® REDIPEN VIAL *(Injection supplies included)*

Weight	Strength	Directions (1.5ug/kg/wk)
☐ <88lbs	☐ 50ug/0.5ml	☐ Inject 0.5ml SC Qweek
☐ 89-110lbs	☐ 80ug/0.5ml	☐ Inject 0.4ml SC Qweek
☐ 111-132lbs	☐ 80ug/0.5ml	☐ Inject 0.5ml SC Qweek
☐ 133-165lbs	☐ 120ug/0.5ml	☐ Inject 0.4ml SC Qweek
☐ 166-187lbs	☐ 120ug/0.5ml	☐ Inject 0.5ml SC Qweek
☐ >187lbs	☐ 150ug/0.5ml	☐ Inject 0.5ml SC Qweek

RIBAVIRIN ® ☐ RibaPak™ ☐ 200mg tablets ☐ 200mg capsules
☐ Take _____mg po qam & _____mg po qpm
Quantity: _____ **Refills:** _____

HEPATITIS B

☐ Baraclude® 0.5mg ☐ Baraclude® 1mg ☐ Tyzeka® 600mg
☐ Hepsera® 10mg ☐ Epivir HBV® 100mg ☐ Viread®
Directions: _____
Quantity: _____ Refills: _____

PROTEASE INHIBITORS

INCIVEK™ (telaprevir) ☐ 375 mg tabs
Directions: Oral – 750 mg (2 tabs of 375 mg each) take orally three times daily every 7-9 hours with food. Take in week 1 through 12 of pegylated interferon therapy.
Quantity: 28 day supply Refills: Maximum 12 weeks of therapy

VICTRELIS™ (boceprevir) 200 mg tabs
Directions: Oral - 800mg (4 caps of 200 mg each) take orally three times daily (every 7-9 hours) with food. Begin after week 4 of Pegylated interferon therapy
Quantity: 28 day supply Refills: _____

INFLAMMATORY BOWEL DISEASE

CIMZIA ® Cimzia Starter Kit 200mg/1 mL Prefilled Syringe 200mg vial
☐ Crohns Induction dose: Inject subcutaneously 400mg (2 vials) on day 1, and at weeks 2 and 4.
☐ Crohns Maintenance Dose: Inject subcutaneously 400mg (2 vials) every 4 weeks.
Quantity: _____ Refills: _____

HUMIRA ® ☐ Crohns ☐ Ulcerative Colitis ☐ 40mg Pen ☐ 40mg Prefilled Syringe
☐ Induction: Inject subcutaneously 160mg (4 pens) on day 1, then 80mg (2 pens) on day 15, then maintenance dosing.
☐ Maintenance: Inject 40mg (1 injection) SC every other week.
☐ Other:_____
Quantity: _____ Refills: _____

REMICADE ® ☐ Crohns ☐ Ulcerative Colitis ☐ 100mg vial
☐ Induction: IV at 5mg/kg (Dose=_____mg) at 0, 2, and 6 weeks.
☐ Maintenance Dose: IV at 5mg/kg (Dose=_____mg) every 8 weeks.
☐ Other: _____
Quantity: _____ (# of 100mg vials) Refills: _____

SIMPONI ®
☐ Ulcerative Colitis Induction Dose: 200 mg initially administered by subcutaneous injection at Week 0, followed by 100 mg at Week 2, and then 100 mg every 4 weeks.
☐ Ulcerative Colitis Maintenance Dose: 100 mg administered by subcutaneous injection every 4 weeks
Quantity: _____ **Refills:** _____

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	Hospital/Clinic:
Phys. Phone:	Phys. Fax:	Address:	Office Contact:

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Physician; ☐ Other_____ *All the supplies including syringes and needles will be dispensed if requested above.*

☐ Patient is interested in support programs

Physician Signature: _____ Per state law must write out DAW (if applicable): _____ Date: _____

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

 Rev. 07.21.2013