MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

GASTROENTEROLOGY

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ CANASA	☐ 1000MG SUPPOSITORY	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN	[30]	
☐ CIMZIA	☐ 200MG PFS ☐ 200MG SDV	☐ STARTER DOSE: INJECT 400 MG SQ AT WEEKS 0, 2 AND 4 ☐ MAINTENANCE DOSE: INJECT 400 MG SQ EVERY 4 WEEKS		
☐ DUPIXENT	☐ 300MG PFS ☐ 300MG AUTOINJECTOR	☐ INJECT 300MG SUBQ ONCE WEEKLY		
☐ CORTIFOAM	☐ 10% FOAM	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN	[15] GRAM CAN	
☐ CREON	☐ 3000U CAPSULE ☐ 6000U CAPSULE ☐ 12000U CAPSULE ☐ 24000U CAPSULE ☐ 36000U CAPSULE	☐ TAKE_____CAPSULES_____TIME(S) DAILY		
☐ CUPRIMINE	☐ 250MG CAPSULE	☐ TAKE_____CAPSULES_____TIME(S) DAILY		
☐ EOHILIA	☐ 2MG/10ML ORAL SUSPENSION	☐ TAKE 2MG ORALLY TWICE DAILY	[60]	
☐ HUMIRA CF	☐ 40MG PFS ☐ 40MG PEN ☐ 80MG PFS ☐ 80MG PEN	☐ INJECT_____MG SQ EVERY_____WEEKS		

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone numbers set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (855) 595-2955

MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

GASTROENTEROLOGY

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ KONVOMEP	☐ 2MG/84MG PER ML ORAL SOLUTION	☐ TAKE_____ML BY MOUTH EVERY_____HOURS		
☐ LINZESS	☐ 72MCG CAPSULE ☐ 145MCG CAPSULE ☐ 290MCG CAPSULE	☐ TAKE 1 CAPSULE BY MOUTH ONCE DAILY	[30]	
☐ PANCREAZE	☐ 2600U CAPSULE ☐ 4200U CAPSULE ☐ 10500U CAPSULE ☐ 16800U CAPSULE ☐ 21000U CAPSULE ☐ 37000U CAPSULE	☐ TAKE_____CAPSULES_____TIME(S) DAILY		
☐ PLENVU	☐	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN	1 KIT	
☐ RECTIV	☐ 0.4% OINTMENT	☐ APPLY INTRA-ANALLY EVERY 12 HOURS, OR AS DIRECTED BY A HEALTHCARE PROFESSIONAL	[30] gram tube	
☐ RINVOQ	☐ 15MG TABLET ☐ 30MG TABLET ☐ 45MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ SIMPONI	☐ 100MG PFS ☐ 100MG SMARTJECT	☐ STARTER DOSE: INJECT 200 MG SQ AT WEEK 0 AND 100 MG SQ AT WEEK 2 ☐ MAINTENANCE DOSE: INJECT 100 MG SUBQ EVERY 4 WEEKS		

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone numbers set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (855) 595-2955

MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

GASTROENTEROLOGY

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ SKYRIZI	☐ 180mg/1.2mL Cartridge with On-Body injector ☐ 360mg/2.4mL Cartridge with On-Body injector	☐ INJECT 180MG SQ AT WEEK 12 AND EVERY 8 WEEKS THEREAFTER ☐ INJECT 360MG SQ AT WEEK 12 AND EVERY 8 WEEKS THEREAFTER		
☐ STELARA	☐ 90MG PFS	☐ INJECT 90 MG SUBQ 8 WEEKS AFTER FIRST IV DOSE, THEN EVERY 8 WEEKS THEREAFTER		
☐ SUPREP		☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN	1 KIT	
☐ SUTAB	☐ 1.479G TABLET	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN	1 KIT	
☐ TALICIA	☐ 10MG/250MG/12.5MG CAPSULES	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN	[84]	
☐ TREMFYA	☐ 200MG PFS ☐ 200MG ONE TOUCH INJECTOR	☐ ADMINISTER 400MG SQ AT WEEK 0, WEEK 4, AND WEEK 8		
☐ TRULANCE	☐ 3MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ VELSIPITY	☐ 2MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ VOQUEZNA	☐ 10MG TABLET ☐ 20MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ UCERIS	☐ 2MG FOAM ☐ 9MG TABLET	☐ APPLY RECTALLY, TWICE DAILY FOR 2 WEEKS, THEN ONCE DAILY FOR 4 WEEKS ☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	1 KIT 30 TABLETS	

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone numbers set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (855) 595-2955

MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

GASTROENTEROLOGY

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:		Secondary Insurance:	
ID#:	RxBin:	ID#:	RxBin:
RxGroup:	Pcn:	RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ XELJANZ	☐ 5 mg Tablet ☐ 10 mg Tablet ☐ 11 mg XR Tablet ☐ 22 mg XR Tablet	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY ☐ TAKE 1 TABLET BY MOUTH TWICE DAILY		
☐ XIFAXAN	☐ 200MG TABLET ☐ 550MG TABLET	☐ TAKE_____MG_____TIME(S) DAILY	[30] OR [60]	
☐ ZEPOSIA	☐ 0.23MG/0.46MG CAPSULES (7 DAY STARTER PACK) ☐ 0.46MG/0.92MG CAPSULES (28 DAY STARTER PACK) ☐ 0.92MG CAPSULES	☐ TAKE 1 CAPSULE BY MOUTH ONCE DAILY		
☐ ZENPEP	☐ 3000U CAPSULES ☐ 5000U CAPSULES ☐ 10000U CAPSULES ☐ 15000U CAPSULES ☐ 20000U CAPSULES ☐ 25000U CAPSULES ☐ 40000U CAPSULES ☐ 60000U CAPSULES	☐ TAKE_____CAPSULES_____TIME(S) DAILY		

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone numbers set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (855) 595-2955