EVENTUS Rx

QUICKER ACCESS, BETTER OUTCOMES

Fort Myers, FL Phone: 866-249-2696 Fax: 866-330-7487
E-Prescribe: NPI # 1770090482 Visit Us Online: eventusrx.com

GASTROENTEROLOGY Prescription Order Form

DATE: _____ NEEDS BY DATE: _____
SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER _____

Patient Information

Patient Name
Address
City, State, Zip
Main Phone Alternate Phone
Social Security #
Date of Birth ☐ Male ☐ Female

Provider Information

Prescriber Name
DEA # NPI # License #
Address
City, State, Zip
Phone Fax
Contact Person

Clinical Information

Diagnosis Code: ☐ K50.90 Crohn's Disease ☐ K51.90 Ulcerative Colitis
☐ Other: _____

Drug Allergies: _____

History: Has the patient been treated previously for this condition? ☐ Yes ☐ No

☐ NSAIDS	Duration _____
☐ MTX	Duration _____
☐ Biologics	Duration _____
☐ Sulfasalazine	Duration _____
☐ 5-ASA (5-Aminosalicylates)	Duration _____
☐ Azathioprine	Duration _____
☐ Corticosteroid	Duration _____
☐ 6-MP (6-Mercaptopurine)	Duration _____
☐ Other	Duration _____

- Is the patient currently on any therapy? ☐ Yes ☐ No
- List Meds: _____
- Will patient stop taking meds before starting the new med? ☐ Yes ☐ No
- How long will the patient wait before starting the new med? _____
- Other meds patient is on? _____
- Has patient received PPD (skin test)? ☐ Yes ☐ No
- Results: _____

Product	Quantity	Prescription Information	Supply	Refills
☐ Cimzia®	☐ 200x2 Prefilled Syringe ☐ 200x2 LYO Powder	☐ Starter Kit: Inject 400mg subcutaneously at Weeks 0,2 and 4 ☐ Inject 400mg subcutaneously once every 4 weeks	1 Kit 4 week supply	none
☐ Creon®	☐ 3,000 ☐ 6,000 ☐ 12,000 ☐ 24,000 ☐ 36,000	Take __ capsules three times daily with meals and __ capsules with __ snacks daily for a total of _____ capsules a day	_____	_____
☐ Dificid®	200mg Tablet	1 tablet by mouth twice a day with or without food for 10 days.	20	_____
☐ Entyvio®	300mg Vial	☐ Loading Dose: Infuse 300mg IV over 30 minutes at Week 0, Week 2 and Week 6 ☐ Maintenance: Infuse 300mg IV over 30 minutes every 8 weeks	3 _____	none _____
☐ Humira®	☐ Crohn's/UC Starter Package (6mg - 40mg Pens) ☐ 40mg Pen ☐ 40mg PFS	Inject 160mg given as ☐ Four 40mg SubQ Day 1 OR ☐ Two 40mg SubQ Days 1 & 2 then Week 2 inject 80mg (Two 40mg injections) subcutaneously on Day 15 ☐ Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	none _____
☐ Humira® Citrate Free	☐ Crohn's/UC Starter Package (3mg - 80mg Pens) ☐ 40mg Pen ☐ 40mg PFS	Inject 160mg given as ☐ Two 80mg SubQ Day 1 OR ☐ One 80mg SubQ Days 1 & 2 then Week 2 inject 80mg subcutaneously on Day 15 ☐ Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	none _____
☐ Remicade® Wt: _____	100mg Vial	Loading Dose: ☐ Infuse _____ mg IV on Week 0, Week 2, Week 6, then Maintenance: ☐ Infuse _____ mg IV every _____ weeks for _____ infusions	Loading Dose 4 week supply	none _____
☐ Simponi®UC	☐ 100mg SmarJect ☐ 100mg Prefilled Syringe	☐ Inject 200mg subcutaneously at week 0, then 100mg at week 2, 100mg every 4 weeks, ☐ Inject 100mg subcutaneously once every 4 weeks	Loading Dose 4 week supply	none _____
☐ Epipen®	0.3mg	Inject 1 pen intramuscularly once, may repeat if necessary. Call 911 if needed.	2	_____
☐ Stelara®	90mg Prefilled Syringe	Inject 90mg subcutaneously every 8 weeks Infusion Dose Date: _____	8 week supply	_____
☐ Xeljanz®	☐ 10mg ☐ 5mg	1 tablet by mouth twice a day	60	_____
☐ Xifaxan®	550mg Tablets	☐ 1 tablet by mouth twice a day ☐ 1 tablet by mouth three times a day	1 month supply 2 week supply	_____ _____
☐ Other	_____	_____	_____	_____

PLEASE FAX COPY OF : 1) PRESCRIPTION CARD FRONT & BACK 2) CLINICAL NOTES 3) MEDICAL CARD FRONT & BACK

By signing this form and utilizing our services, you are authorizing Eventus Rx, Inc to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date