POLARIS SPECIALTY RX

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Polaris Specialty Pharmacy
410 Cloverleaf Drive
Baldwin Park, CA 91706
NPI: 1053486795

GASTROENTEROLOGY ORDER FORM

Ship to: ☐ Patient ☐ Physician ☐ Other

All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Patient Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____

Alternate Contact Info: _____

Allergies: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information

Gender: ☐ Male ☐ Female BSA: _____

Height: _____ Weight: _____

TB test given: ☐ Yes ☐ No
Does patient have an active infection?
☐ Yes ☐ No

Start Date: _____

Review Date: _____

Diagnosis: Date of Diagnosis: _____

☐ B18.1 Hepatitis B
☐ K58.0 IBS w/Diarrhea
☐ K50.90 Crohn's Disease
☐ K76.82 Hepatic Encephalopathy
☐ A09 Traveler's Diarrhea
☐ K51.90 Ulcerative Colitis
☐ K20.0 Eosinophilic Esophagitis

☐ Other Diagnosis: ICD-10 Code: _____

Description: _____

Tried and Failed History:

Medication: _____ Duration: _____

Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side Effects ☐ Other: _____

Prescription Information

	Medication	Dose/Strength	Directions	Qty	Refills
HBV	☐ Vemlidy	☐ 25mg	☐ Take 1 tablet by mouth once daily with food	30 tab	_____
HEPATIC	☐ Xifaxan	☐ 200mg ☐ 550mg Drugs tried & failed: ☐ Lactulose ☐ Neomycin ☐ Other: _____ Date: _____	☐ **Traveler's Diarrhea:** Take 200mg PO TID x3days	9 tab	None
			☐ **Hepatic Encephalopathy:** Take 550mg PO BID	60 tab	_____
			☐ **IBS w/Diarrhea:** Take 550mg PO TID x14days	42 tab	None
			☐ Other _____	_____	_____
CROHNS DISEASE / ULCERATIVE COLITIS	☐ Cimzia	☐ Starter Kit 200mg ☐ 200mg/ml Prefilled syringe	☐ **Initial Dose:** Inject 400mg SQ once, then repeat at week 2 and 4 ☐ **Maintenance:** Inject 400mg SQ every 4 weeks	6 SYR 2 SYR	None _____
	☐ Cyltezo	☐ 40mg/0.8ml Single Dose PF Pen ☐ 40mg/0.8ml Single Dose PF Glass Syringe	☐ **Initial Dose:** Inject 160mg SQ on day 1 (give in one day or split over 2 consecutive days), then 80mg on day 15 ☐ **Maintenance:** Inject 40mg SQ every other week starting day 29 ☐ Other _____	6 2 _____	None _____ _____
	☐ Humira	☐ Citrate Free Crohn's/UC Starter Pack (80mg/0.8ml x3pens) ☐ Citrate Free 40mg/0.4ml Pen ☐ Citrate Free 40mg/0.4ml PFS	☐ **Initial Dose:** Inject 160mg SQ on day 1, then 80mg on day 15 ☐ **Maintenance:** Inject 40mg SQ every other week starting day 29 ☐ Other _____	3 2	None _____
	☐ Rinvoq	☐ 15mg ER tablet ☐ 30mg ER tablet ☐ 45mg ER tablet	☐ **Initial Dose (UC):** Take 45mg PO QD x8weeks ☐ **Initial Dose (CD):** Take 45mg PO QD x12weeks ☐ **Maintenance:** Take 15mg PO QD ☐ Other _____ *(Maintenance dose of 30mg QD may be considered for patients with refractory, severe, or extensive disease)*	28 28 30 _____	1 2 _____ _____
	☐ Simponi	☐ 100mg/ml autoinjector ☐ 100mg/ml prefilled syringe	☐ **Initial Dose:** Inject 200mg SQ at week 0, then 100mg at week 2 ☐ **Maintenance:** Inject 100mg SQ every 4 weeks starting on week 6	3 1	None _____

Referral form continued on the next page

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CROHNS DISEASE / ULCERATIVE COLITIS	☐ Stelara	☐ 130mg/25mg SDV ☐ 90mg/ml Prefilled Syringe	**Initial Dose:** ☐ **≤ 55kg:** 260mg (2 vials) IV as single dose ☐ **55kg to 85kg:** 390mg (3 vials) IV as single dose ☐ **> 85kg:** 520mg (4 vials) IV as single dose ☐ **Maintenance:** Inject 90mg SQ every 8 weeks; begin maintenance dose 8 weeks after the IV induction dose	2 vials 3 vials 4 vials 1 SYR	None None None _____
	☐ Xeljanz	☐ 5mg tablet ☐ 10mg tablet	☐ **Initial Dose:** 10mg PO BID x8weeks or _____ weeks **Maintenance Dose:** ☐ 5mg PO BID ☐ 10mg PO BID	_____ 60 tab	_____ _____
	☐ Zeposia	☐ Starter Kit ☐ 0.92mg capsules	☐ **Initial Dose:** Titration Regimen Day 1-4: Take 0.23mg PO QD Day 5-7: Take 0.46mg PO QD Day 8 and thereafter: Take 0.92mg PO QD ☐ **Maintenance:** Take 0.92mg po QD	1 Kit (37 caps) 30 caps	0 _____
OTHER	☐ Dupixent *(12+ years old, ≥ 40kg)*	☐ 300mg/2ml Prefilled Pen ☐ 300mg/2ml Prefilled Syringe	☐ Inject 300mg SQ every week	4	_____
	☐ Skyrizi	☐ 600mg/10ml Vial ☐ 360mg/2.4ml Prefilled Cartridge	☐ **Initial Dose:** 600mg IV at week 0, 4, 8 ☐ **Maintenance Dose:** 360mg SQ every 8 weeks starting at week 12	3 vials 1	None _____
	☐ Other	_____	☐ Other: _____	_____	_____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script.

I authorize Polaris Specialty Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ ☐ **Dispense as written (DAW) Date:** _____/_____/_____

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