HEALTH GUARD

CROHN'S | HEPATITIS B

Phone: (323) 222-8882
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1833B E. Cesar E Chavez Ave
Los Angeles, CA 90033-2415

Date Medication Needed: _____ Ship To: ◯ Patient's Home ◯ Prescriber's Office

1. Patient/Insurance Information

Patient Name: _____ Birthdate: _____ Sex: ◯ Male ◯ Female Height: _____ Weight: _____ ◯ lbs. ◯ kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Caregiver Name: _____ Preferred Phone: _____

2. Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: _____ ICD-10: _____

PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY.

Medication	Strength	Directions/SIG	Qty.	Refill
Dificid	☐ 200mg tabs	☐ Take 1 tablet twice daily with or without food for 10 days		
☐ **Humira** ☐ Injection training from My Humira **(patient must sign below)**	☐ 20mg Pen ☐ 20mg Pre-Filled Syringe ☐ 40mg Pre-Filled Syringe ☐ 40mg Pre-Filled Syringe ☐ Starter Pack	**Induction Dose:** ☐ Inject 160mg SC (four 40mg Pens) for first Dose (Day 1). Then Inject 80mg SC (two 40mg Pen) two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29) **Maintenance Dose:** ☐ Inject 40mg SC (one 40mg Pen) every other week		
Simponi	☐ 100mg SmartJect ☐ 100mg Pre-filled Syringe	**Induction Dose:** ☐ Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 **Maintenance Dose:** ☐ 100mg SC every 4 weeks starting at week 6, after Induction dose		
Cimzia	☐ Prefilled Syringes (2x200mg) (or) ☐ Lyophilized vials (2 x 200mg)	**Induction Dose:** ☐ Inject 400mg SC at weeks 0, 2, and 4 **Maintenance Dose:** ☐ 400mg SC every 4 weeks		
Remicade	☐ 100mg vial			
Entyvio	☐ 300mg vial			
Xifaxan	☐ 200mg tabs ☐ 550mg tabs	Take: _____ tablets _____ times per day		

HEPATITIS B				Directions:	Qty.	Refills
☐ B18.1 Hepatitis B ☐ Baraclude 0.5mg ☐ Hepsera 10mg	☐ Baraclude 1mg ☐ Epivir HBV 100mg	☐ Tyzeka 600mg ☐ Viread	☐ Xifaxan 200mg ☐ Xifaxan 550mg	_____		

Other: _____

3. Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____ Phone: _____

Signature: _____ **Date:** _____

I authorize Health Guard Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.