XUBEX® Specialty Pharmacy Services
www.Xubex.com

Patient Intake Form-GASTROENTEROLOGY

3796 Howell Branch Road • Winter Park, FL 32792
Phone: 866-699-8239

FAX THIS FORM TO 866-495-3304

PATIENT INFORMATION

First:	Last:	M.I.:	☐Male ☐ Female	
Date of Birth:	SSN:		Best Phone:	
Address:	City:		State:	Zip:
Shipping Address (if different from home address):			Height:	Weight:

PRESCRIBER INFORMATION

First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION

Primary:	PCN:	BIN#	**Secondary:**	PCN:	ID#:
Phone:	ID#:	Group#	Phone:	BIN#	Group#
Prescription Drug Insurer:	Phone:		RxGrp#:	RxBIN#:	PCN/ID#:

CLINICAL INFORMATION

TB Test Results: ☐ Negative ☐ Positive Date_____ | If positive has patient been treated? ☐ Yes ☐ No

Primary Diagnoses: ☐ Psoriatic Arthropathy ICD 696 ☐ Other Psoriasis and similar disorders ICD 696.1 ☐ Other_____

Allergies:

Failed Therapies and Dates:

Current Therapies/Medications:

Will patient stop taking the above medications before starting the new medication? ☐ Yes ☐ No | If yes, what is the washout period?

Does the patient have any co-morbid infections? ☐ Yes ☐ No | Plaque Psoriasis Severity: ☐ Mild ☐ Moderate to Severe ☐ Severe

☑ PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)

Humira®

Humira® Starting Dose:

160mg SC x one dose, followed by 80mg SC on day 15

☐ **Humira**®Pen Crohn's Disease/Ulcerative Colitis Starter Pkg: 40mg/pen; 6/box

☐ **Humira**® PFS #6

Humira® Maintenance Dosing:

Humira® 40mg SC every 2 weeks ☐ Pen ☐ PFS

Humira® 40mg SC every week ☐ Pen ☐ PFS

Qty:_____ Refills:_____ ☐ 1 Year

Other:_____

Other

Medication Name: _____Strength_____

Frequency: _____Route_____

Directions:_____

Qty:_____ Refills:_____ ☐ 1 Year

Remicade® (Must be shipped to MD office)

Patient current weight:_____lbs/kg Dose per kg_____

☐ Remicade® single use 100mg vials qty_____vials

☐ Sterile water for injection; 10ml/vial qty_____vials

☐ Normal saline flush; 10ml/PFS qty_____syringes

Refills: _____

Cimzia®

Cimzia® Starting Dose:

☐ 200mg/ml PFS Starter Kit
Initial dose of 400mg SC at weeks 0, 2, and 4- 1 Kit

☐ Cimzia® 200mg single use prefilled syringes 6/box

Cimzia® Maintenance Dosing:

☐ 200mg SC every 2 weeks

☐ 400mg SC every 4 weeks; 200mg SC every 2 weeks

Qty: 2 Syringes (1 box) Refills:_____ ☐ 1 Year

ADDITIONAL INSTRUCTIONS

Please Deliver To: ☐ Patient's Home ☐ Dr.'s Office ☐ 1st dose to MD's office, remaining refills to patient's home

Physician's Signature: | Date: