ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY
www.acropharmacy.com

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GIASSIST®
ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 12.04.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY
www.commcarepharmacy.com
Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: Diagnosis (ICD-10-CM codes) □K50.0 Regional Enteritis or Crohn's of Small Intestine □K51.90 Ulcerative Colitis
□K50.10 Regional Enteritis or Crohn's of Large Intestine □K50.90 Regional Enteritis or Crohn's Disease NOS □Other:_____
Date of Diagnosis:_____ OR Years with Disease:_____

Injection Training & Education Needs: □Specialty Pharmacy Injection Training □Manufacturer's Patient Assistance Program Enrollment
□Prescriber's office will train patient □Prescriber's office already trained patient □Patient is already independently injecting

Requested Clinical Information: *(as applicable)* Does patient have a latex allergy? □Yes □No
Has Hepatitis B been ruled out? □Yes □No Does patient have serious/active infection? □Yes □No Has TB test been performed? □Yes □No If Yes, Results _____

Previous Therapies:
_____

Drug Name	Strength	Directions	Quantity	Refill
□Cimzia®	□Cimzia Starter Kit (6 syringes) □Prefilled Syringe 200mg/Ml (2 syringes) □Lyophilized powder pack (2 x 200mg/vial)	□**INITIAL:** □Inject 400mg SQ at weeks 0,2, & 4 **MAINTENANCE:** □Inject 400mg SQ every 4 weeks □Inject 200mg SQ every 2 weeks □Other:_____	**INITIAL:** □Starter kit x 1 (6 PFS) □3 boxes (6 vials) **MAINTENANCE:** □4 week supply □Other:_____	
□Humira®	***Citrate Free Starter Kit*** □80mg/0.8mL CD PEDIATRIC #3 PFS □80mg/0.8mL+40mg/0.4mL CD PEDIATRIC #2 PFS □80mg/0.8mL CD/UC/HS #3 PEN ***Citrate Free Maintenance Kit*** □10mg/0.1mL PFS □20mg/0.2mL PFS □40mg/0.4mL PEN □40mg/0.4mL PFS ***Non-Citrate Free Starter Kit*** □40mg/0.8mL CD/UC/HS PEDIATRIC #6 PFS □40mg/0.8mL CD/UC/HS PEDIATRIC #3 PFS □40mg/0.8mL CD/UC/HS #6 PEN ***Non-Citrate Free Maintenance Kit*** □10mg/0.2mL PFS □20mg/0.4mL PFS □40mg/0.8mL PEN □40mg/0.8mL PFS	***Adult*** □**INITIAL:** Inject 160mg SQ on day 1, then 80mg on day 15, then maintenance on day 29 □**MAINTENANCE:** Inject 40mg SQ every OTHER week □Other:_____ ***Child 17kg (37lbs) to <40kg (88lbs)*** □**INITIAL:** Inject 80mg SQ on day 1, then 40mg on day 15, then maintenance on day 29 □**MAINTENANCE:** Inject 20mg SQ every OTHER week ***Child ≥ 40kg (88lbs)*** □**MAINTENANCE:** Inject 160mg SQ on day 1, then 80mg on day 15, then maintenance on day 29 □**MAINTENANCE:** Inject 40mg SQ every OTHER week □Other:_____	**INITIAL:** □Starter kit x 1 **MAINTENANCE:** □4 week supply □Other:_____	
□Simponi®	□100mg/mL SmartJect Autoinjector □100mg/mL Prefilled Syringe	□**INITIAL:** Inject 200mg SQ at week 0, 100mg at week 2, then maintenance dose at week 6 □**MAINTENANCE:** Inject 100mg SQ every 4 weeks □Other:_____	**INITIAL:** □3 SmartJect Autoinjectors □3 Prefilled Syringes **MAINTENANCE:** □4 week supply □Other:_____	
□Stelara®	□90mg/mL Prefilled Syringe	**MAINTENANCE:** Inject 90mg SQ every 8 weeks □Other:_____	□**MAINTENANCE:** 8 weeks □Other:_____	
□Xeljanz®	□5mg Tablet □10mg Tablet	□Take 10mg by mouth TWICE daily □Other:_____	□30 day supply □Other:_____	
□Other			**PFS = prefilled syringe, PEN = prefilled pen** **CD = Crohn's Disease, UC = Ulcerative Colitis, SQ = subcutaneously**	

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation):_____ Date:_____ □Please select if you would like the patient enrolled in a Manufacturer's Assistance Program