Fax:
Phone:

Crohn's / Ulcerative Colitis Enrollment Form

PATIENT INFORMATION

Please complete the following or ***send patient demographic sheet***

Patient Name ______
Address ______
Address 2 ______
City, State, Zip ______
Home Phone ______ Alternate Phone ______
DOB ______ Last Four of SS# ______ Gender ______
Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______
DEA ______
NPI ______
Group / Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Contact Person ______ Phone ______

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number: ______

MEDICAL INFORMATION *(Section must be completed to process prescription) (Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications
☐ Other Diagnosis: ICD-10 Code ______ Description ______
Date of diagnosis ______
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg/lbs Height ______ cm/in
Allergies ______
Lab Data ______
Prior Therapies ______
Concomitant Medications ______
Additional Comments ______
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Qty	Refills
☐ Cimzia®	☐ 200 mg / mL Vial Kit ☐ 200 mg / mL Starter Kit ☐ 200 mg / mL Prefilled Syringe	☐ Initiation - Inject 400 mg SQ at Weeks 0, 2, and 4 ☐ Maintenance - Inject 400 mg SQ every 4 weeks		
☐ Entyvio®	☐ 300 mg Vial	☐ Initiation - Infuse 300 mg IV over 30 minutes at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 300 mg IV over 30 minutes every 8 weeks		
☐ Humira®	☐ 20 mg/0.4 mL PFS ☐ 20 mg/0.2 mL PFS (citrate-free) ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.4 mL PFS (citrate-free) ☐ 40 mg/0.8 mL PFS - Pediatric CD Starter Pack ☐ 80 mg/0.8 mL & 40 mg/0.4 mL PFS - Pediatric CD Starter Pack (citrate-free) ☐ 80 mg/0.8 mL PFS - Pediatric Starter Pack (citrate-free) ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.4 mL Pen (citrate-free) ☐ 40 mg/0.8 mL Pen - CD/UC/HS Starter Pack ☐ 80 mg/0.8 mL Pen - CD/UC/HS Starter Pack (citrate-free)	Adult ☐ Initiation: Inject 160 mg SQ on Day 1 (given in one day or split over two consecutive days), then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29) Pediatric (≥ 6 years and adolescents) **17 kg to <40 kg** ☐ Initiation: Inject 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1 (given in one day or split over two consecutive days), then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29)		
☐ Inflectra®	☐ 100 mg Vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Remicade®	☐ 100 mg Vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Renflexis®	☐ 100 mg Vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Simponi®	☐ 100 mg/mL SmartJect Autoinjector ☐ 100 mg/mL Prefilled Syringe	☐ Initiation - Inject 200 mg SQ at Week 0 then 100 mg at Week 2 ☐ Maintenance - Inject 100 mg SQ every 4 weeks		
☐ Stelara®	☐ 130 mg/26 mL solution single dose vial ☐ 90 mg/mL Prefilled Syringe	☐ Initiation - Infuse: ☐ 260 mg ☐ 390 mg ☐ 520 mg as initial IV dose as directed by prescriber ☐ Maintenance - Inject 90 mg SQ every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
☐ Xeljanz®	☐ 5 mg Tablet ☐ 10 mg Tablet	☐ Initiation: Take 10 mg po twice daily for 8 weeks ☐ Maintenance: ☐ Take 5 mg po twice daily ☐ Take 10 mg po twice daily		

Ship to: ☐ Patient ☐ Office ☐ Other ______ Date ______ Needs by Date ______

****Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature: ______ Date: ______

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.