Crohn's / Colitis Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

(*Complete the following or include demographic sheet*)

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ DOB: _____

Alternate Phone: _____

Gender: ☐ Male ☐ Female

Primary Language: _____

PRESCRIBER INFORMATION

Name: _____

State License #: _____ NPI #: _____

DEA #: _____

Group or Hospital: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION

If available, please fax copy of prescription insurance cards with this form (front and back).

MEDICAL INFORMATION

Prior Failed Medication(s):	Reason for Discontinuing	Length of Treatment
☐ 5-ASA ☐ Corticosteroids		____/____/____-____/____/____
☐ Immunosuppressants (6-MP or other)		____/____/____-____/____/____
☐ Methotrexate ☐ Other		____/____/____-____/____/____

Date of Diagnosis: ____/____/____

- ☐ K50.00 Regional enteritis of small intestine
- ☐ K50.10 Regional enteritis of large intestine
- ☐ K50.80 Regional enteritis of small intestine with large intestine
- ☐ K50.90 Regional enteritis of unspecified site
- ☐ K51.80 Ulcerative enterocolitis
- ☐ K51.80 Ulcerative ileocolitis
- ☐ K51.50 Left-sided ulcerative colitis
- ☐ K51.00 Universal ulcerative colitis
- ☐ K51.90 Ulcerative colitis, unspecified

Other: _____

TB/PPD Test Results:
- ☐ Negative
- ☐ Positive

Hepatitis B ruled out or being treated:
- ☐ Yes
- ☐ No

Allergies: _____

Patient's Weight: _____

Prior biologic use: Date of last dose:
- ☐ Remicade® _____
- ☐ Humira® _____
- ☐ Simponi® _____
- ☐ Cimzia® _____

PRESCRIPTION

Drug		Directions & Quantity	Refills
Cimzia®	☐ Prefilled Syringe ☐ Lyophilized Powder	☐ **INITIAL:** Inject 400mg SQ on day 1, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200mg SQ every 2 weeks (Quantity: 2)	
Humira®	☐ Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160mg SQ on day 1, then 80mg on day 14 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40mg SQ every other week (Quantity: 2)	
Remicade®	☐ Vials	☐ **INITIAL**: Infuse _5mg/____kg=_____mg on day 0, 14, and 42 (Quantity: _____) ☐ **MAINTENANCE:** Infuse _____mg every 8 weeks (Quantity: _____)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 200mg SQ on day 1, then 100mg on day 14 (Quantity: 3) ☐ **MAINTENANCE:** Inject 100mg SQ every 4 weeks (Quantity: 1)	
Entyvio®	☐ 300mg in 20 mL Vial	☐ **INITIAL / MAINTENANCE** : Week zero two and six weeks, then every eight weeks thereafter	

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Pharmacy to coordinate injection training or infusion

PHYSICIAN SIGNATURE

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: _____ **Date**: _____