



Updated July 2019

Patient Name _____ Today's Date _____ NEW Patient CURRENT Patient
 DOB _____ Height _____ Weight _____ Male Female Preferred Language _____
 Best Phone _____ Email _____
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Ship to Patient at: Home Physician Office Work Address _____
 Allergies _____
 Current Medications including OTC's (please fax a complete list) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
 Relation to Patient _____
Primary Insurance _____
 ID# _____ Group # _____
Secondary Insurance _____
 ID# _____ Group # _____

Ordering Prescriber

Office Contact _____
 Street Address _____ Suite # _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____
 Email _____
 License# _____
 NPI# _____

ICD-10 Code **Crohn's Disease** K50.00 K51.50 K50.10 K51.80 K50.80
Ulcerative Colitis K51.90 K50.90
 Yes No Active TB ruled out? Date: _____ Yes No TB/PPD Test given? Date: _____
 Yes No Chest X-Ray? Results _____ Yes No Hep B is ruled out / treated?

Previous Meds	Strength	Duration of Treatment	Not Tolerated	Contraindications
Methotrexate	_____	_____	_____	_____
Pentasa	_____	_____	_____	_____
Entocort	_____	_____	_____	_____
Humira	_____	_____	_____	_____
Cimzia	_____	_____	_____	_____
Enbrel	_____	_____	_____	_____

PRESCRIPTION

PRIOR | CURRENT TREATMENTS

Azathioprine Corticosteroids 5-ASA 6-MP NSAIDS Methotrexate Sulfasalazine
 Other _____ Dose | Duration _____

CIMZIA 200mg PFS SD Vial

SIG: **Starting dose:** 400 mg subcutaneously initially and at weeks 2 & 4 QTY: 6 Refill: _____
 Maintenance dose: 400 mg subcutaneously every 4 weeks QTY: _____ Refill: _____

ENTYVIO 300 mg single-use 20 mL vial

SIG: **Starting dose:** 300 mg infused intravenously over approximately 30 minutes on week 0, week 2 & week 6 then, QTY: _____ Refill: _____
 Maintenance dose: 300 mg infused every 8 weeks QTY: _____ Refill: _____

HUMIRA STARTER KIT 80 mg/0.8mL PFS Pens

SIG: **Starting dose:** Day 1: Inject 160 mg subcutaneously; Day 15: Inject 80 mg subcutaneously QTY: 3 Refill: 0
 Starting dose: Day 1: Inject 80 mg subcutaneously; Day 2 : Inject 80 mg subcutaneously;
 Day 15: Inject 80 mg subcutaneously QTY: 3 Refill: 0

HUMIRA 40 mg/0.4mL PFS Pens **HUMIRA CITRATE-FREE 40 mg/0.4mL** | PFS Pens

SIG: **Maintenance dose:** Day 29: Inject 40 mg/0.8 ml every other week QTY: _____ Refill: _____
 Other: _____ QTY: _____ Refill: _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.



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Patient Name, Today's Date, NEW Patient, CURRENT Patient, DOB, Height, Weight, Male, Female, Preferred Language, Best Phone, Email, Street Address, Apt#, City, State, Zip, Ship to Patient at: Home, Physician Office, Work Address, Allergies, Current Medications including OTC's (please fax a complete list)

Please Fax Insurance Card(s) both sides

Insured's Name, Relation to Patient, Primary Insurance, ID#, Group #, Secondary Insurance, ID#, Group #

Ordering Prescriber

Office Contact, Street Address, Suite #, City, State, Zip, Tel, Fax, Email, License#, NPI#

ICD-10 Code, Crohn's Disease, Ulcerative Colitis, K50.00, K51.90, K50.10, K51.80, K50.80, Active TB ruled out?, Date, TB/PPD Test given?, Date, Chest X-Ray? Results, Hep B is ruled out / treated?

Table with 5 columns: Previous Meds, Strength, Duration of Treatment, Not Tolerated, Contraindications. Rows include Methotrexate, Pentasa, Entocort, Humira, Cimzia, Enbrel.

PRESCRIPTION

PRIOR | CURRENT TREATMENTS, Azathioprine, Corticosteroids, 5-ASA, 6-MP, NSAIDS, Methotrexate, Sulfasalazine, Other, Dose | Duration

REMICADE 100 mg vial, MD Office Infusion, Infusion supplies needed?, YES, NO, SIG: Starting dose: 5 mg/kg, Maintenance dose: 5 mg/kg, QTY, Refill

Ulcerative Colitis only, SIMPONI, SmartJect, PFS, SIG: Starting dose: 200 mg subcutaneously at week 0, then 100 mg subcutaneously at week 2, QTY: 3 (100 mg/mL), Maintenance dose: 100 mg subcutaneously every 4 weeks, QTY: 1 (100 mg/mL), Other, QTY, Refill

Crohn's Disease only, STELARA, 130 mg/26 mL SD Vial, 45mg PFS, 90mg PFS, 45mg SD Vial, SIG: Starting dose: Infuse mg IV initially, then maintenance, Maintenance dose: Inject 90 mg subcutaneously 8 weeks after the initial IV dose, then every 8 weeks, QTY, Refill, Weight of Pt (Kg), Recmd Dosage, Vials

Ulcerative Colitis only, XELJANZ, 5 mg tablet, 10 mg tablet, SIG: Starting dose: mg orally twice a day with or without food for weeks, QTY, Refill, Maintenance dose: mg orally twice a day, QTY, Refill

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