



Crohn's/Ulcerative Colitis Enrollment Form

Specialty Pharmacy Fax: 1-781-805-8245
Specialty Pharmacy Phone: 1-844-319-7588

① PATIENT INFORMATION			
Patient Name		Date of Birth	
Address		Primary Phone	
City	State	Alternate Phone	
Zip Code	Gender	Email	
	Male	Female	
Primary Language			

② PRESCRIBER INFORMATION	
Prescriber's Name	License #
DEA #	NPI #
Group or Hospital Name	Contact Person
Address	Phone
City, State, Zip Code	Fax

③ INSURANCE INFORMATION
Please fax copy of prescription and insurance cards with applicable pre-authorization approvals with this form, if available.

④ MEDICAL INFORMATION	⑤ ADDITIONAL INFORMATION
Diagnosis – Please include diagnosis name with ICD-10 code <input type="checkbox"/> K50.00 Crohn's disease of small intestine without complications <input type="checkbox"/> K50.10 Crohn's disease of large intestine without complications <input type="checkbox"/> K50.80 Crohn's disease of small & large intestine without complications <input type="checkbox"/> K50.90 Crohn's disease, unspecified, without complications <input type="checkbox"/> K51.0 Ulcerative pancolitis <input type="checkbox"/> K51.5 Left-sided colitis <input type="checkbox"/> K51.8 Other ulcerative colitis <input type="checkbox"/> K51.9 Ulcerative colitis, unspecified <input type="checkbox"/> Other diagnosis: ICD-10 code: _____ Description: _____ Date of diagnosis: _____	Therapy: <input type="checkbox"/> New <input type="checkbox"/> Refill <input type="checkbox"/> Restart Weight: _____ kg/lb Height: _____ cm/in Allergies: _____ Has a TB test been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is interested in patient support programs? <input type="checkbox"/> Yes <input type="checkbox"/> No Injection training needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> MD office <input type="checkbox"/> Infusion clinic Need by date: _____

⑥ PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Cimzia Starter Kit	<input type="checkbox"/> Induction dose: Inject 400mg SC once on day 1 then repeat at weeks 2 and 4	1 kit	0
	<input type="checkbox"/> 200mg/ml prefilled syringe	<input type="checkbox"/> Maintenance dose: Inject 400mg SC once every 4 weeks		
	<input type="checkbox"/> 200mg/ml vial			
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> Induction dose: Infuse 300mg IV over 30 minutes at weeks 0, 2 and 6 <input type="checkbox"/> Maintenance dose: Infuse 300mg IV over 30 minutes every 8 weeks		
	<input type="checkbox"/> Humira Crohn's Starter Kit <input type="checkbox"/> Humira Crohn's Starter Kit (citrate free)	<input type="checkbox"/> Induction dose: Inject 160mg SC on day 1 then 80mg on day 15	1 kit	0
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.4ml pen (citrate free)	<input type="checkbox"/> Maintenance dose: Inject 40mg SC every other week starting day 29		
	<input type="checkbox"/> 40mg/0.4ml syringe (citrate free)			
	<input type="checkbox"/> 40mg/0.8ml pen			
	<input type="checkbox"/> 40mg/0.8ml syringe			
<input type="checkbox"/> Inflectra®	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Induction dose: Infuse IV at 5mg/kg over at least 2 hours at weeks 0, 2 and 6		
		<input type="checkbox"/> Maintenance dose: Infuse IV at 5mg/kg over at least 2 hours every 8 weeks		
		<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Induction dose: Infuse IV at 5mg/kg over at least 2 hours at weeks 0, 2 and 6		
		<input type="checkbox"/> Maintenance dose: Infuse IV at 5mg/kg over at least 2 hours every 8 weeks		
		<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100mg/ml SmartJect prefilled autoinjector	<input type="checkbox"/> Induction dose: Inject 200mg SC at week 0 then 100mg at week 2		
	<input type="checkbox"/> 100mg/ml prefilled syringe	<input type="checkbox"/> Maintenance dose: Inject 100mg SC every 4 weeks		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 130mg/26ml (5mg/ml) vial	Induction dose:		0
		<input type="checkbox"/> ≤55kg: Infuse 260mg IV over at least 1 hour as a single dose	<input type="checkbox"/> 2 vials	
		<input type="checkbox"/> 55-85kg: Infuse 390mg IV over at least 1 hour as a single dose	<input type="checkbox"/> 3 vials	
	<input type="checkbox"/> >85kg: Infuse 520mg IV over at least 1 hour as a single dose	<input type="checkbox"/> 4 vials		
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> _____		
	<input type="checkbox"/> 90mg/ml prefilled syringe	<input type="checkbox"/> Maintenance dose: Inject 90mg SC every 8 weeks		

*Ancillary supplies provided as needed for administration

STAMP SIGNATURE NOT ALLOWED

X _____ X _____
 SUBSTITUTION ALLOWED (Date) DISPENSE AS WRITTEN (Date)

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