SPECIALTY PHARMACY™
Crohn's / Ulcerative Colitis Enrollment Form

Pharmacy Phone: _____

Fax completed forms and prescriptions to _____ or electronically prescribe to Target Pharmacy #XXXX

Date Needed: _____ Preferred Pharmacy Pickup Location: _____

Patient Information

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Email address: _____

Insurance Provider (Please include a copy of front and back of card): _____

ID #: _____ Policy/Group #: _____ Phone #: _____

Name of Insured: _____ Relationship to Insured: _____ Employer: _____

Prescription Card: ☐ Yes ☐ No Carrier: _____ Policy/Group #: _____

Clinical Assessment

Diagnosis/ICD-9	Prior History	Prior Biologic Use:	Date of Last Dose:
CD: ☐ 555.0 ☐ 555.1 ☐ 555.2 ☐ 555.9 UC: ☐ 556.5 ☐ 556.6 ☐ 556.8 ☐ 556.9	☐ 5-ASA ☐ Immunosuppressants (6-MP or other) ☐ Corticosteroids ☐ Methotrexate ☐ Surgery ☐ Other: _____	☐ Remicade® ☐ Humira® ☐ Simponi® ☐ Cimzia® ☐ Other (please specify)	_____ _____ _____ _____ _____
Date of Diagnosis: _____ Does patient have negative TB test results? ☐ Y ☐ N *Date of Test:* _____			

Prescription Information

Medication	Dose	Directions/Frequency	Quantity	Refills
☐ Cimzia®	☐ Cimzia® Starter Kit (PFS)	**Induction Dose:** ☐ 400 mg Sub-Q at weeks 0, 2 and 4	☐ 1 Kit = 6 x 200 mg/mL PFS 3 cartons = 6 x 200 mg	0
	☐ 200 mg/mL PFS	**Maintenance Dose:** ☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200 mg/mL PFS	
☐ Humira®	☐ **Humira Induction Dose** ☐ 40 mg Pens ☐ 40 mg PFS	**Induction Dose:** ☐ 160 mg Sub-Q day 1, 80 mg day 15, 40 mg day 29 and every other week thereafter	☐ 1 Kit = 6 x 40 Pens ☐ 3 Cartons = 6 x 40 mg PFS	0
	☐ 40 mg Pens ☐ 40 mg PFS	**Maintenance Dose:** ☐ 40 mg Sub-Q every other week	☐ 1 Carton = 2 x 40 mg Pens ☐ 1 Carton = 2 x 40 mg PFS	
☐ Simponi®	☐ 100 mg/mL SmartJect® Autoinjector	**Induction Dose:** ☐ 200 mg Sub-Q at week 0, 100 mg at week 2 and every 4 weeks thereafter	☐ 3 x 100 mg SmartJect® Autoinjector ☐ 3 x 100 mg PFS	0
	☐ 100 mg/ml PFS	**Maintenance Dose:** ☐ 100 mg Sub-Q every 4 weeks	☐ 1 x 100 mg SmartJect® Autoinjector ☐ 1 x 100 mg PFS	
☐ Remicade®	☐ 100 mg Vial		☐ ____x 100 mg Vials	

Prescriber Information

Prescriber's Name: _____ Practice/Facility Name: _____

Prescriber NPI/DEA #: _____ Contact: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ Best Time to Call: _____

Prescriber's Signature: _____ Date: _____

Pharmacy can accept only original hardcopy prescription drug orders from patients. Faxed prescriptions must be sent directly from prescribing practitioners.

SXX