# **Crohn's Disease** Enrollment Form

PRx

## PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ - ____ - ____
Address: _____
City: _____ State: _____ Zip: _____

Phone: ( ____ ) - ____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: Medications: (Please attach additional pages if necessary)

## PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____Clinic/Hospital Affiliation: _____

Phone: ( ____ ) - ____ - _____ Fax: ( ____ ) - ____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

CDRX-19-01

## CLINICAL CONSIDERATIONS

Diagnosis:
☐ K50.0 Crohn's disease of the small intestine without complications
☐ K50.1 Crohn's disease of the large intestine without complications
☐ K50.8 Crohn's disease of both intestines without complications
☐ K50.9 Crohn's disease, unspecified without complications
☐ Other: _____

TB Test Completed: ☐ Yes ☐ No
Date of negative test: ____ /____ / ____
*If history of latent TB, has patient received treatment?*
☐ Yes ☐ No
Please list previously tried/failed therapies & dates:

Immunization History
☐ Influenza:
Date: ____ /____ / ____
Hep B Screening:
☐ Positive ☐ Negative
Date: ____ /____ / ____

## Rx

| Medication | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ **Cimzia®** (certolizumab pegol) | **Initial Dose**<br>☐ Cimzia Starter Kit (six 200 mg prefilled syringes) | ☐ Inject 400 mg subcutaneously (two 200 mg injections) at weeks 0, 2, and 4, then maintenance dose | 1 kit | 0 |
| | **Maintenance Dose**<br>☐ 200 mg prefilled syringe<br>☐ 200 mg vial | ☐ Inject 400 mg subcutaneously (two 200 mg injections) every 4 weeks | | |
| ☐ **Entyvio®** (vedolizumab) | ☐ 300 mg vial | ☐ **Initial Dose**: Infuse 300 mg IV over 30 minutes at 0, 2, and 6 weeks, then maintenance dose<br>☐ **Maintenance Dose**: Infuse 300 mg IV over 30 minutes every 8 weeks | | |
| ☐ **Humira®** (adalimumab) | **Initial Dose**<br>Crohn's/Ulcerative Colitis Starter Package:<br>☐ 40 mg/0.8 mL (six pens)<br>☐ 80 mg/0.8 mL (three pens) **Citrate-free** | ☐ Inject 160 mg subcutaneously on day 1, then 80 mg on day 15, then maintenance dose<br>☐ Inject 80 mg subcutaneously over 2 consecutive days, then 80 mg on day 15, then maintenance dose | 1 kit | 0 |
| | **Maintenance Dose**<br>☐ 40 mg/0.8 mL pen<br>☐ 40 mg/0.4 mL prefilled syringe **Citrate-free**<br>☐ 40 mg/0.8 mL prefilled syringe<br>☐ 40 mg/0.4 mL pen **Citrate-free** | ☐ Inject 40 mg subcutaneously every other week | | |
| ☐ **Inflectra®** (infliximab-dyyb) | ☐ 100 mg vial<br>*Patient Dosing Weight:* _____kg | ☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose (Dose= _____ mg)<br>☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks (Dose= _____ mg)<br>☐ Other: _____ | _____ # of 100 mg vials | |
| ☐**Remicade®** (infliximab) | ☐ 100 mg vial<br>*Patient Dosing Weight:* _____kg | ☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose (Dose= _____ mg)<br>☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks (Dose= _____ mg)<br>☐ Other: _____ | _____ # of 100 mg vials | |
| ☐ **Renflexis®** (infliximab-abda) | ☐ 100 mg vial<br>*Patient Dosing Weight:* _____kg | ☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose (Dose= _____ mg)<br>☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks (Dose= _____ mg)<br>☐ Other: _____ | _____ # of 100 mg vials | |
| ☐ **Stelara®** (ustekinumab) | **Initial Dose**<br>☐ 130 mg vial | ☐ Infuse _____ mg IV over no less than one hour | | |
| | **Maintenance Dose**<br>☐ 90 mg prefilled syringe | ☐ Inject 90 mg subcutaneously every 8 weeks; begin maintenance dose 8 weeks after the IV induction<br>☐ Other: _____ | | |

**Injection Training**
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

**Prescriber's signature:** _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

## SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____