Ulcerative Colitis Enrollment Form (A-R)

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 #: _____

UCRXA-R-19-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ K51.0 Ulcerative pancolitis
☐ K51.5 Left-sided ulcerative colitis
☐ K51.8 Other ulcerative colitis
☐ K51.9 Ulcerative colitis, unspecified
☐ 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
☐ **Entyvio®** (vedolizumab)	☐ 300 mg vial	☐ **Initial Dose**: Infuse 300 mg IV over 30 minutes at 0, 2, and 6 weeks, then maintenance dose ☐ **Maintenance Dose**: Infuse 300 mg IV over 30 minutes every 8 weeks		
☐ **Humira®** (adalimumab)	**Initial Dose** Crohn's/Ulcerative Colitis Starter Package: ☐ 40 mg/0.8 mL (six pens) ☐ 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 ☐ Inject 80 mg subcutaneously over 2 consecutive days, then 80 mg on day 15, then maintenance dose	1 kit	0
	Maintenance Dose ☐ 40 mg/0.8 mL pen ☐ 40 mg/0.4 mL prefilled syringe **Citrate-free** ☐ 40 mg/0.8 mL prefilled syringe ☐ 40 mg/0.4 mL pen **Citrate-free**	☐ Inject 40 mg subcutaneously every other week		
☐ **Inflectra®** (infliximab-dyyb)	☐ 100 mg vial *Patient Dosing Weight:* _____kg	☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose (Dose = _____ mg) ☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks (Dose = _____ mg) ☐ Other: _____	_____ # of 100 mg vials	
☐ **Remicade®** (infliximab)	☐ 100 mg vial *Patient Dosing Weight:* _____kg	☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose (Dose = _____ mg) ☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks (Dose = _____ mg) ☐ Other: _____	_____ # of 100 mg vials	
☐ **Renflexis®** (infliximab-abda)	☐ 100 mg vial *Patient Dosing Weight:* _____kg	☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose (Dose = _____ mg) ☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks (Dose = _____ mg) ☐ Other: _____	_____ # of 100 mg vials	

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: ____ /____ / ____