# **Ulcerative Colitis** Enrollment Form (S-Z)

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 #: _____

UCRXS-Z-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 |
|---|---|---|---|---|
| ☐ **Simponi®** (golimumab) | ☐ 100 mg SmartJect® autoinjector<br>☐ 100 mg prefilled syringe | ☐ **Initial Dose**: Inject 200 mg subcutaneously at week 0, then 100 mg at week 2, then maintenance dose<br>☐ **Maintenance Dose**: Inject 100 mg subcutaneously every 4 weeks<br>☐ Other: _____ | | |
| ☐ **Xeljanz®** (tofacitinib) | ☐ 5 mg tablets | ☐ **Initial Dose**: Take two tablets (10 mg) by mouth twice daily for 8 weeks, then maintenance dose<br>☐ **Maintenance Dose**: Take one tablet (5 mg) by mouth twice daily<br>☐ **Maintenance Dose**: Take two tablets (10 mg) by mouth twice daily<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: ____ /____ / ____