GASTROENTEROLOGY ENROLLMENT FORM

DATE: ______________________ SHIP TO: ☐ PATIENT ☐ OFFICE
DATE NEEDED: ________________

PATIENT INFO

NAME ________________ E-MAIL ________________ DOB ____________ ☐ MALE ☐ FEMALE
ADDRESS ________________ CITY ________________ STATE ______ ZIP ________
HOME TELEPHONE ________________ MOBILE PHONE ________________ SS# ____________

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

Diagnosis Codes

Date of Diagnosis: ____________________
☐ K50.00____ Crohn's Disease
☐ K51.80____ Ulcerative Colitis
☐ Other: ____________________

Treatment History

☐ New to this medicine ☐ Continued Treatment
If continuing treatment, has patient's condition improved or stabilized? ☐ Yes ☐ No
Patient Weight:______kg / lb
Allergies? ☐ Latex ☐ Other: ____________
Concomitant Medications: ____________
Crohn's/UC Severity: ☐ Moderate ☐ Severe ☐ Mild
Presence of Enterocutaneous/Rectovaginal Fistulas? ☐ Yes ☐ No
Has patient been diagnosed with Heart Failure? ☐ Yes ☐ No
Has patient been diagnosed with Lymphoma? ☐ Yes ☐ No
Does patient have serious/active infection? ☐ Yes ☐ No
TB/PPD Test Results? ☐ No ☐ Yes ☐ Result? ________
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No - If Yes, has Hepatitis B been ruled out or treatment started? ☐ Yes ☐ No
☐ Other: ____________________

Prior Failed Medication(s)

Medication ____________________
Length of Treatment __________ **to** __________
Reason for Discontinuing ____________________

Medication ____________________
Length of Treatment __________ **to** __________
Reason for Discontinuing ____________________

Medication ____________________
Length of Treatment __________ **to** __________
Reason for Discontinuing ____________________

Manufacturer's Support: Is patient enrolled in the product manufacturer's sponsored support program? *(example: myHUMIRA, AccessOne)* ☐ Yes ☐ No

PRESCRIPTION INFORMATION

☐ Cimzia® *(Crohn's)*

☐ **Starter Dose:**
- ☐ Starter Kit (200mg Pre-filled Syringe)
- ☐ Vial (200mg/ml) & supplies

☐ **Starter Directions:**
- ☐ Inject 400mg SC at weeks 0, 2, and 4
- ☐ Other: ________

QTY: ☐ 1 pre-fill syr KIT (6x200mg syr) ☐ 6 vials ☐ ______ | **Refills**_____

☐ **Maintenance Dose:**
- ☐ Pre-filled Syringe (200mg/ml)
- ☐ Vial (200mg/ml) & supplies

☐ **Maintenance Directions:**
- ☐ Inject 400mg SC every 4 weeks
- ☐ Other: ________

QTY: ☐ 2 pre-filled syr ☐ 4 vials ☐ ________ | **Refills**________

☐ Humira® *(Crohn's - UC)*

☐ Crohn's/Ulcerative Colitis Starter Kit

☐ **Induction Dose:**
- ☐ Inject 160mg (4 pens) SC on day 1 , then 80mg Kit(2 pens) on day 15, then maintenance dosing
- ☐ Other: ________

QTY: ☐ 1 KIT | **Refills**_____

☐ **Maintenance Dose:**
- ☐ Pen (40mg/0.8ml)
- ☐ 40mg/0.8ml Prefilled Syringe (PFS)

☐ **Maintenance Directions:**
- ☐ Pen: Inject 40mg (one pen) SC every other week
- ☐ PFS: Inject 40mg (one syringe) SC every other week
- ☐ Other: ________

QTY: ☐ 2 ☐ _____ | **Refills**_____

☐ Simponi® *(UC)*

- ☐ SmartJect Autoinjector (100mg/ml)
- ☐ Prefilled Syringe (100mg/ml)

☐ **Initial Dosing:**
- ☐ Inject 200mg(2 autoinj/syringes) SC on week 0, then 100mg (1 autoinj/syringe) on week 2, then 100mg (1 autoinj/syringe) every 4 weeks

☐ **Maintenance Dosing:**
- ☐ Inject 100mg (1 pen/syringe) SC every 4 weeks

QTY: ☐ 3 autoing/syr on first dispense, and 1 for refills ☐ 1 autoinj/syr ☐ ________ | **Refills**________

☐ Other

Drug Name: ____________________
☐ Strength: ____________
☐ Directions: ____________

QTY: ☐ __________ | **Refills**______

☐ Entyvio® *(Crohn's/UC)*

☐ 300mg/20ml Vial

☐ **Initial Directions:**
- ☐ Administer 300mg via IV infusion at Weeks 0, 2, and 6, then maintenance dosing.
- ☐ Other: ________

☐ **Maintenance Directions:**
- ☐ Administer 300mg via IV infusion every 8 weeks.
- ☐ Other: ________

QTY: ☐ _____vials | **Refills**_____

☐ Remicade® *(Crohn's/UC)*

☐ Vial (100mg/20ml)

☐ **Initial Dosing:**
- ☐ Administer 5 mg/kg (Dose = _____mg) at 0, 2, & 6 weeks, then q 8 weeks

☐ **Maintenance Dosing:**
- ☐ Administer ________mg/kg every ________ weeks
- ☐ Other: ________

QTY: ☐ ____Vials | **Refills**______

Supportive Care

☐ Methotrexate

☐ 2.5 mg tablets ☐ 25 mg/ml vials

☐ **Dosing:**
☐ ____________________

QTY: ☐ ______ | **Refills**______

☐ Other

Drug Name: ____________________
☐ Strength: ____________________
☐ Directions: ____________________

QTY: ☐ _______ | **Refills**_______

INJECTION TRAINING ☐ Patient has received injection training ☐ Physician Office to provide injection training ☐ Pharmacy to provide injection training

PRESCRIBER INFORMATION

Prescriber's Name: ____________________ Contact Person: ____________________
Telephone: ________________ Fax: ________________ Email: ________________
Office Address: ____________________ City: ____________ State: ______ Zip: ________
NPI # : ____________ DEA # : ____________ Tax ID # : ____________ Medicaid Provider # : ____________

____________________ ____________ * ____________________
PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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