Crohn's Disease & Ulcerative Colitis Enrollment Form

Phone: 800-476-7496
Fax: 888-985-9223

PATIENT INFORMATION (PLEASE PRINT)			
Patient Name (Last, First, Mi)			☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	SS#	Phone (Daytime)	Phone (Evening)
Street Address (Please include Suite/Apt Number)	City	State	Zip

INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT'S PHARMACY BENEFIT CARD - FRONT AND BACK)		
Primary Insurance		Policy Holder
Policy #	Group #	Phone

DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)			
☐ 555.0 Crohn's Disease	☐ 555.1 Crohn's Disease	☐ 555.2 Crohn's Disease	☐ 555.9 Crohn's Disease
☐ 556.0 Ulcerative Colitis	☐ 556.1 Ulcerative Colitis	☐ 556.2 Ulcerative Colitis	☐ 556.9 Ulcerative Colitis
☐ Other ICD9 ___________________________		Is patient new to therapy? ☐ yes ☐ no Date of Diagnosis: ______/______/_______	
Patient tested for TB: ☐ yes ☐ no If yes, Date ____/____/______ Result: ☐ Positive ☐ Negative			
Patient Weight: ______________________		Drug Allergies: ___________________________ **OR** ☐ NKDA	

PREVIOUS MEDICATIONS (Please specify dosage and time on therapy)		
Medication Strength and Dose	*Date of Therapy*	*Reason for Discontinuing*

PRESCRIPTION INFORMATION			
Rx-Medication	*Dose and Frequency*	*Quantity*	*Refills*
Humira® (adalimumab)			
☐ Humira® Crohn's Disease Start Pk 6 - Self-Injectable Pens 40 mg/0.8 ml	☐ Four (#4) 40 mg (0.8ml) subcutaneously injections day 1 (160mg) and Two (#2) 40 mg 0.8ml) subcutaneously injections day 15 (80mg) ☐ Other: ____	☐ 28 day supply	None
☐ Humira® Self-Injectable Pen 40 mg/0.8 ml ☐ Humira® Pre-Filled syringe 40 mg/0.8 ml	☐ 40 mg (0.8ml) subcutaneously injection once every other week ☐ Other: ____	☐ 28 day supply ☐ 84 day supply ☐ Other: ______	☐ 1 year ☐ Other: ______
Cimzia® (certolizumab pegol)			
☐ Cimzia® Starter Kit 6 - 200mg prefilled syringes	☐ Two (#2) 200 mg prefilled syringes SC day 1 (400mg); and, Two (#2) 200 mg prefilled syringes SC (400mg) at end of week 2 and Two (#2) 200 mg prefilled syringes SC (400mg) at end of week 4 ☐ Other: ____	☐ 28 day supply	None
☐ Cimzia® Maintenance Dose 2 – 200 mg prefilled syringes ☐ Cimzia® Maintenance Dose 2 – 200 mg vials	☐ Two (#2) 200 mg prefilled syringes SC (400mg) every 4 weeks ☐ Other: ____	☐ 28 day supply ☐ 84 day supply ☐ Other: ______	☐ 1 year ☐ Other: ______
☐ Remicade® (infliximab) 100 mg / 20 ml vial	Not for Self Administration	# _____________	

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS			
☐ Patient's Home	☐ Physician's Office	Date Needed	Patient needs Education Kit? ☐ yes ☐ no
Teaching to be done at:	☐ Patient's Home ☐ Physician's Office ☐ Not needed		

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION			
Physician Name	License #	DEA #	UPIN #
Office Contact	Phone	Fax	NPI#
Street Address (Please include Suite Number)		City/State/Zip	
Physician's Signature (required)		Date (required)	

This prescription will be filled generically unless Prescriber writes "DAW" in the box to the right. [ ]