Crohn's/Ulcerative Colitis
Enrollment Form

Phone: 844-309-7171
Fax: 844-309-7173

1. PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies	☐ NKDA
Date of Birth	SSN#	Weight ____________ ☐ kg ☐ lb date	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address(optional)	

2. INSURANCE INFORMATION

Primary Insurance	Pharmacy insurance BIN__________ PCN________	Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

3. DIAGNOSIS/MEDICAL INFORMATION (PLEASE ANSWER ALL QUESTIONS TO PREVENT A DELAY IN PATIENT'S THERAPY.)

☐ K50.90 Crohn's Disease NOS	☐ K50.0 Crohn's - small Intestine	☐ K50.01 Crohn's – large intestine	☐ Other ICD 10 ____________
Severity type: ☐ mild ☐ moderate to severe	Has the patient had a NEGATIVE tuberculin skin test, or if positive, has treatment for latent TB been initiated prior to anti-TNF therapy? ☐ yes ☐ no	Does the patient have a clinically important active infection? ☐yes ☐ no	

4. PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
☐ Cimzia®	200mg/Pen	☐ Induction dosing 400mg (2 pens) SC week 2, week 4, week 6	6 pens	Ø
		☐ Maintenance dosing 400mg (2 pens) SC every 4 weeks	2 pens	
☐ Humira®	40mg/Pen	☐ Induction dosing 160mg (4 pens) SC week 0, 80mg (2 pens) week 2 (starter kit)	6 pens	Ø
		☐ Maintenance dosing 40mg (1 pen) SC every other week	2 pens	
☐ Simponi® (UC)	100mg/Pen	☐ Induction dosing 200mg (2 pens) SC day 1, 100mg (1 pen) day 15 (starter kit)	3 pens	Ø
		☐ Inject 100mg (1 pen) SC every other week	1 pen	
		☐ Prefilled Syringes OR ☐ SmartJect® autoinjector		
☐ Stelara®	90mg/Pen	☐ begin 90mg SC 8 wks after initial IV infusion, then every 8 weeks after	1 pen	
☐ Other				

5. DELIVERY INSTRUCTIONS

☐ Physicians Office	☐ Other	Date Medication Needed
☐ Patient's Home	Address	
	City/State/Zip	

6. PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	
License #	DEA #	

Physician's Signature ____ **Date** ________________
(required to process prescription – stamped signatures are not permissible)

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173.
Faxed prescription forms will only be accepted from prescribing practitioners.