RxReach
Your Connection to Better Health

Crohn's/ Ulcerative Colitis Enrollment Form

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______________________

Address ______________________

Address 2 ______________________

City, State, Zip ______________________

Home Phone ______________________ Alternate Phone ______________________

DOB __________ Last Four of SS# __________ Gender __________

Language Preference: ☐ English ☐ Spanish ☐ Other __________

PRESCRIBER INFORMATION

Prescriber's Name ______________________

DEA ______________________

NPI ______________________

Group/ Hospital ______________________

Address ______________________

City, State, ZIP ______________________

Phone ______________________ Fax ______________________

Contact Person ______________________ Phone ______________________

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number: ______________________

MEDICAL INFORMATION *(Section must be completed to process prescription) (Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications

☐ K50.10 Crohn's disease of large intestine without complications

☐ K50.90 Crohn's disease, unspecified, without complications

☐ Other Diagnosis: ICD-10 Code ________ Description_ Date of diagnosis _

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Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date __________ **Review Date** __________

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight __________ kg/lbs Height __________ cm/in

Allergies ______________________

Lab Data ______________________

Prior Therapies ______________________

Concomitant Medications ______________________

Additional Comments ______________________

Injection Training Required: Yes No

PRESCRIPTION INFORMATION

Medication	Dose/ Strength	Directions	Qty	Refills
☐ Cimzia®	☐ 200 mg/ mL Vial Kit ☐ 200 mg/ mL Starter Kit ☐ 200 mg/ mL Prefilled Syringe	☐ Initiation - Inject 400 mg SQ at Weeks 0, 2, and 4 ☐ Maintenance - Inject 400 mg SQ every 4 weeks		
☐ Entyvio®	☐ 300 mg Vial	☐ Initiation - Infuse 300 mg IV over 30 minutes at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 300 mg IV over 30 minutes every 8 weeks		
☐ Humira®	☐ 20 mg/0.4 mL PFS ☐ 20 mg/0.2 mL PFS (citrate-free) ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.4 mL PFS (citrate-free) ☐ 40 mg/0.8 mL PFS - Pediatric CD Starter Pack ☐ 80 mg/0.8 mL & 40 mg/0.4 mL PFS - Pediatric CD Starter Pack (citrate-free) ☐ 80 mg/0.8 mL PFS - Pediatric Starter Pack (citrate-free) ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.4 mL Pen (citrate-free) ☐ 40 mg/0.8 mL Pen - CD/UC/HS Starter Pack ☐ 80 mg/0.8 mL Pen - CD/UC/HS Starter Pack (citrate-free)	Adult ☐ Initiation: Inject 160 mg SQ on Day 1 (given in one day or split over two consecutive days), then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29) Pediatric (≥ 6 years and adolescents) **17 kg to <40 kg** ☐ Initiation: Inject 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1 (given in one day or split over two consecutive days), then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29)		
☐ Inflectra®	☐ 100 mg Vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Remicade®	☐ 100 mg Vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Renflexis®	☐ 100 mg Vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Simponi®	☐ 100 mg/mL SmartJect Autoinjector ☐ 100 mg/mL Prefilled Syringe	☐ Initiation - Inject 200 mg SQ at Week 0 then 100 mg at Week 2 ☐ Maintenance - Inject 100 mg SQ every 4 weeks		
☐ Stelara®	☐ 130 mg/26 mL solution single dose vial ☐ 90 mg/mL Prefilled Syringe	☐ Initiation - Infuse: ☐ 260 mg ☐ 390 mg ☐ 520 mg as initial IV dose as directed by prescriber ☐ Maintenance - Inject 90 mg SQ every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
☐ Xeljanz®	☐ 5 mg Tablet ☐ 10 mg Tablet	☐ Initiation: Take 10 mg po twice daily for 8 weeks ☐ Maintenance: ☐ Take 5 mg po twice daily ☐ Take 10 mg po twice daily		

Ship to: ☐ Patient ☐ Office ☐ Other ______________________ Date ______________________ Needs by Date ______________________

* *Prescriber Authorization:* I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature: ______________________ Date: __________

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