Fax Referral To:
814-283-2211

www.vsprx.com

Phone: 855-265-8008

CD/UC Enrollment Form

Ship to:
☐ **Patient**
☐ **Office**
☐ **Other:**

Date: _____ **Needs by Date:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Prescription Card: __ ID# _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: __ _____ Name of Insurer: _____ Phone: _____
Secondary Insurance: __ _____ Name of Insurer: _____ Phone: _____ _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-10:

_____
_____
_____
_____

• Date of Diagnosis: _____

Additional Clinical Information: Therapy: ☐ New ☐ Reauthorization ☐ Restart

• Weight: _____ kg/lbs • Height: _____ in/cm
• Allergies: _____
• Lab Data: _____
• Concomitant Medications: _____
• Additional Comments: _____

• Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No • If Yes, Date: _____

• Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No *Agency of Choice: _____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia Starter Kit	☐ 400mg	Inject 400mg (2 vials) subcutaneously on day 1 and at weeks 2 and 4.	#1 kit	0
☐ Cimzia Prefilled Syringe ☐ Cimzia Vial	☐ 200mg ☐ 200mg	☐ Inject 200mg subcutaneously every 2 weeks. ☐ Inject 400mg (2 vials) subcutaneously every 4 weeks.	#2	
☐ Entyvio Loading Dose ☐ Entyvio Maintenance	☐ 300mg	☐ Administer at 0, 2 and 6 weeks ☐ Administer every 8 weeks	☐ 3 vials ☐ 1 vial	
☐ Humira Crohn's Starter	☐ 40mg/0.8ml	Inject 4 pens (160mg) subcutaneously on day one. 14 days later inject 2 pens (80mg) subcutaneously. Then begin maintenance.	#1 kit	0
☐ Humira Maintenance	☐ 40mg/0.8ml	Inject 1 syringe (40mg) subcutaneously once every other week.	#2 syringes	
☐ Remicaide 100mg SDV Loading Dose	Dose _____mg/kg, Total dose _____mg	☐ Administer at 0,2 and 6 weeks ☐ Other: _____	___ vials	
☐ Remicaide 100mg SDV Maintenance Dose	Dose _____mg/kg, Total dose _____mg	☐ Administer every 8 weeks ☐ Other: _____	____vials	
☐ Simponi	☐ 100mg Autoinjector	☐ Initial – 200mg SC at week 0 and 100mg SC at week 2 ☐ Maintenance – 100mg SC every 4 weeks	____ injectors	
☐ Xifaxan	☐ 200mg ☐ 550mg	☐ Take one tablet _____ times per day for ____ days.		

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

Physician Signature _____ Date _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right