



# Crohn's / Ulcerative Colitis Enrollment Form

Date: \_\_\_\_\_

Patient Data

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs kg  
 SSN #: XXX-XX-\_\_\_\_ Known Allergies: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Authorized Contact: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

Ins. Data

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 ID: \_\_\_\_\_ Group#: \_\_\_\_\_ ID: \_\_\_\_\_ Group#: \_\_\_\_\_

Diagnosis

- |   |   |
|---|---|
| <input type="checkbox"/> K50.00 Crohn's Disease of small intestine without complications                | <input type="checkbox"/> K51.20 Ulcerative (chronic) proctitis without complications        |
| <input type="checkbox"/> K50.10 Crohn's Disease of large intestine without complications                | <input type="checkbox"/> K51.30 Ulcerative (chronic) rectosigmoiditis without complications |
| <input type="checkbox"/> K50.80 Crohn's Disease of both small and large intestine without complications | <input type="checkbox"/> K51.50 Left sided colitis without complications                    |
| <input type="checkbox"/> K50.90 Crohn's Disease, unspecified, without complications                     | <input type="checkbox"/> K51.80 Other ulcerative colitis without complications              |
| <input type="checkbox"/> Other: _____   | <input type="checkbox"/> K51.90 Ulcerative colitis, unspecified, without complications      |
| ICD 10: _____   | <input type="checkbox"/> Other: _____   |
|   | ICD 10: _____   |

Clinical Information

To expedite prior authorization, please attach PPD results, lab results, clinical office notes, and past treatment history.

Has patient previously been treated for this condition? Yes No Does patient have a latex allergy? Yes No

If yes, medication/therapy failed (length of therapy): \_\_\_\_\_

Has patient received PPD (tuberculosis) skin test? Yes No Date: \_\_\_/\_\_\_/\_\_\_ Results: Positive Negative

Has patient been tested for Hepatitis B? Yes No If positive, has treatment been initiated? Yes No

Prescription

Medication	Dosage	Directions	Quantity	Refills
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200mg/ml PFS <input type="checkbox"/> 200mg/ml vial	<input type="checkbox"/> Induction: Inject 400mg (two injections) SQ at week 0, 2, and 4 <input type="checkbox"/> Maintenance: Inject 400mg (two injections) SQ every 4 weeks	#6	0 refills
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> Induction: Infuse 300mg intravenously at week 0, 2 and 6 <input type="checkbox"/> Maintenance: Infuse 300mg intravenously every 8 weeks	#3	0 refills
<input type="checkbox"/> Humira®	<input type="checkbox"/> Crohn's Starter Kit (pens only)	<input type="checkbox"/> Induction: Inject 160mg (4 injections) SQ on day 1; Inject 80mg (two injections) SQ on day 15	#6	0 refills
	<input type="checkbox"/> 40mg/0.8ml PFS <input type="checkbox"/> 40mg/0.8ml Pen	<input type="checkbox"/> Maintenance: Inject 40mg SQ every other week		
<input type="checkbox"/> Humira® Citrate Free	<input type="checkbox"/> Crohn's Starter Kit 80mg/0.8ml (pens only)	<input type="checkbox"/> Induction: Inject 160mg (2 injections) SQ on day 1; Inject (1 injection) SQ on day 15	#3	0 refills
	<input type="checkbox"/> 40mg/0.4ml PFS <input type="checkbox"/> 40mg/0.4ml Pen	<input type="checkbox"/> Maintenance: Inject 40mg SQ every other week		
<input type="checkbox"/> Remicade® 100mg/20mL SDV	<input type="checkbox"/> Dose: _____mg/kg Total Dose: _____mg	<input type="checkbox"/> Induction: Infuse intravenously at week 0, 2 and 6 over a period of not less than 2 hours		
	<input type="checkbox"/> Dose: _____mg/kg Total Dose: _____mg	<input type="checkbox"/> Maintenance: Infuse intravenously every 8 weeks over a period of not less than 2 hours		
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100mg Smartject Autoinjector	<input type="checkbox"/> Induction: Inject 200mg (two injections) SQ at week 0; Inject 100mg SQ at week 2	#3	0 refills
	<input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Maintenance: Inject 100mg SQ every 4 weeks		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 130mg/26ml (5mg/ml) SDV	<input type="checkbox"/> Induction: (Dosed by weight) Up to 55kg → 260mg = 2 vials Greater than 55kg to 85kg → 390mg = 3 vials Greater than 85kg → 520mg = 4 vials	<input type="checkbox"/> 2 vials <input type="checkbox"/> 3 vials <input type="checkbox"/> 4 vials	0 refills
	<input type="checkbox"/> 90mg/ml PFS	<input type="checkbox"/> Maintenance: Inject 90mg SQ 8 weeks after initial IV dose, then every 8 weeks thereafter		
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 10mg tablet	<input type="checkbox"/> Induction: Take 10mg orally twice daily for 8 weeks	#60	1 refill
	<input type="checkbox"/> 5mg tablet	<input type="checkbox"/> Take 1 tablet orally twice daily	#60	
	<input type="checkbox"/> 10mg tablet			

Supportive Medication

Medication	Dosage	Directions	Quantity	Refills
<input type="checkbox"/> Difigid®	<input type="checkbox"/> 200mg	<input type="checkbox"/> Take 1 tablet twice daily with or without food for 10 days	<input type="checkbox"/> 20 tablets	
<input type="checkbox"/> Xifaxan®	<input type="checkbox"/> 200mg <input type="checkbox"/> 550mg	<input type="checkbox"/> Take _____ tablet(s) _____ times per day		
<input type="checkbox"/> Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

Is patient new to this therapy:  YES  NO | Ship to:  Patient  Office  Other | Desired Start Date: \_\_\_\_\_

Prescriber Data

Prescribers Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Key Contact#: \_\_\_\_\_

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 process.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

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