Crohn's / Ulcerative Colitis Enrollment Form

VALUE SPECIALTY PHARMACY

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

- ☐ K50.00 Crohn's Disease of small intestine without complications
- ☐ K50.10 Crohn's Disease of large intestine without complications
- ☐ K50.80 Crohn's Disease of both small and large intestine without complications
- ☐ K50.90 Crohn's Disease, unspecified, without complications
- ☐ Other: _____ ICD 10: _____
- ☐ K51.20 Ulcerative (chronic) proctitis without complications
- ☐ K51.30 Ulcerative (chronic) rectosigmoiditis without complications
- ☐ K51.50 Left sided colitis without complications
- ☐ K51.80 Other ulcerative colitis without complications
- ☐ K51.90 Ulcerative colitis, unspecified, without complications
- ☐ 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
☐ Cimzia®	☐ 200mg/ml PFS ☐ 200mg/ml vial	☐ Induction: Inject 400mg (two injections) SQ at week 0, 2, and 4 ☐ Maintenance: Inject 400mg (two injections) SQ every 4 weeks	#6	0 refills
☐ Entyvio®	☐ 300mg vial	☐ Induction: Infuse 300mg intravenously at week 0, 2 and 6 ☐ Maintenance: Infuse 300mg intravenously every 8 weeks	#3	0 refills
☐ Humira®	☐ Crohn's Starter Kit (pens only)	☐ Induction: Inject 160mg (4 injections) SQ on day 1; Inject 80mg (two injections) SQ on day 15	#6	0 refills
	☐ 40mg/0.8ml PFS ☐ 40mg/0.8ml Pen	☐ Maintenance: Inject 40mg SQ every other week		
☐ Humira® *Citrate Free*	☐ Crohn's Starter Kit 80mg/0.8ml (pens only)	☐ Induction: Inject 160mg (2 injections) SQ on day 1; Inject (1 injection) SQ on day 15	#3	0 refills
	☐ 40mg/0.4ml PFS ☐ 40mg/0.4ml Pen	☐ Maintenance: Inject 40mg SQ every other week		
☐ Remicade® 100mg/20mL SDV	☐ Dose: _____mg/kg Total Dose: _____mg	☐ Induction: Infuse intravenously at week 0, 2 and 6 over a period of not less than 2 hours		
	☐ Dose: _____mg/kg Total Dose: _____mg	☐ Maintenance: Infuse intravenously every 8 weeks over a period of not less than 2 hours		
☐ Simponi®	☐ 100mg Smartject Autoinjector ☐ 100mg PFS	☐ Induction: Inject 200mg (two injections) SQ at week 0; Inject 100mg SQ at week 2	#3	0 refills
		☐ Maintenance: Inject 100mg SQ every 4 weeks		
☐ Stelara®	☐ 130mg/26ml (5mg/ml) SDV	☐ Induction: (Dosed by weight) Up to 55kg → 260mg = 2 vials Greater than 55kg to 85kg → 390mg = 3 vials Greater than 85kg → 520mg = 4 vials	☐ 2 vials ☐ 3 vials ☐ 4 vials	0 refills
	☐ 90mg/ml PFS	☐ Maintenance: Inject 90mg SQ 8 weeks after initial IV dose, then every 8 weeks thereafter		
☐ Xeljanz®	☐ 10mg tablet	☐ Induction: Take 10mg orally twice daily for 8 weeks	#60	1 refill
	☐ 5mg tablet ☐ 10mg tablet	☐ Take 1 tablet orally twice daily	#60	

Supportive Medication

Medication	Dosage	Directions	Quantity	Refills
☐ Dificid®	☐ 200mg	☐ Take 1 tablet twice daily with or without food for 10 days	☐ 20 tablets	
☐ Xifaxan®	☐ 200mg ☐ 550mg	☐ Take _____ tablet(s) _____ times per day		
☐ Other	☐ _____	☐ _____		

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.