



Crohn's / Ulcerative Colitis Enrollment Form S-Z

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-_____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ 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	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Simponi® <i>only indicated for UC</i>	<input type="checkbox"/> 100mg/ml PFS <input type="checkbox"/> 100mg/ml Smartject® Autoinjector	<input type="checkbox"/> Induction: Inject 200mg (2 injections) SQ at week 0, then inject 100mg (1 injection) SQ at week 2	#3	0 refills
		<input type="checkbox"/> Maintenance: Inject 100mg SQ every 4 weeks	#1	
<input type="checkbox"/> Stelara®	130mg/26ml vial	<input type="checkbox"/> Induction: (Dosed by weight) Infuse _____mg intravenously as single dose, begin maintenance in 8 weeks <i>Up to 55kg → 260mg = 2 vials</i> <i>Greater than 55kg to 85kg → 390mg = 3 vials</i> <i>Greater than 85kg → 520mg = 4 vials</i> Patient weight _____kg	Quantity Sufficient x1 dose	0 refills
		<input type="checkbox"/> Maintenance: Inject 90mg SQ 8 weeks after initial IV dose, then every 8 weeks thereafter	Quantity Sufficient x1 dose	
<input type="checkbox"/> Xeljanz® <i>only indicated for UC</i>	10mg tablet	<input type="checkbox"/> Induction: Take 1 tablet orally twice daily for 8 weeks	#60	1 refill
	5mg tablet	<input type="checkbox"/> Maintenance: Take 1 tablet orally twice daily	#60	
<input type="checkbox"/> Xeljanz XR® <i>only indicated for UC</i>	22mg tablet	<input type="checkbox"/> Induction: Take 1 tablet orally once daily for 8 weeks	#30	1 refill
	11mg tablet	<input type="checkbox"/> Maintenance: Take 1 tablet orally once daily	#30	

Supportive

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Difcid®	200mg tablet	Take 1 tablet orally twice daily for 10 days	#20	
<input type="checkbox"/> Xifaxan®	<input type="checkbox"/> 200mg tablet	Take _____ tablet(s) orally _____ times per day		
	<input type="checkbox"/> 550mg tablet			

Is patient new to this therapy: YES NO | Ship to: Patient Office Other | Need by Date: _____

Prescriber Data

Prescriber 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.