



# Crohn's/Ulcerative Colitis Enrollment Form A-R

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: \_\_\_\_\_  
 Alternate Caregiver Name/Phone: \_\_\_\_\_ Patient Email: \_\_\_\_\_

Ins. Data

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Policy: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy: \_\_\_\_\_ Group#: \_\_\_\_\_  
 Patient has commercial insurance and authorizes pharmacy to apply for manufacturer copy card. Email must be provided above.

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: _____ ICD 10: _____   | <input type="checkbox"/> K51.90 Ulcerative colitis, unspecified, without complications      |
|   | <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"/> Cimzia®	<input type="checkbox"/> 200mg/ml PFS <input type="checkbox"/> 200mg/ml vial	<input type="checkbox"/> Induction: Inject 400mg (2 injections) SQ at weeks 0, 2, and 4	#6	0 refills
		<input type="checkbox"/> Maintenance: Inject 400mg (2 injections) SQ every 4 weeks	#2	
<input type="checkbox"/> Entyvio®	300mg/20ml vial	<input type="checkbox"/> Induction: Infuse 300mg intravenously at weeks 0, 2, and 6	#3	0 refills
		<input type="checkbox"/> Maintenance: Infuse 300mg intravenously every 8 weeks	#1	
<input type="checkbox"/> Humira® citrate free	<input type="checkbox"/> Crohn's Starter Kit (pens only) <input type="checkbox"/> 40mg/0.4ml PFS <input type="checkbox"/> 40mg/0.4ml Pen	Induction: Inject 160mg (2 pens) SQ on day 1, then inject 80mg (1 pen) SQ on day 15	#3	0 refills
		Maintenance: Inject 40mg SQ once every 2 weeks	#2	
<input type="checkbox"/> Remicade® <input type="checkbox"/> Avsola™ infliximab biosimilar <input type="checkbox"/> Inflectra® infliximab biosimilar <input type="checkbox"/> Renflexis infliximab biosimilar	100mg/20ml vial	<input type="checkbox"/> Induction: Infuse 5mg/kg intravenously at weeks 0, 2, and 6 Patient weight _____kg	Quantity Sufficient x3 doses	0 refills
		<input type="checkbox"/> Maintenance: Infuse 5mg/kg intravenously every 8 weeks Patient weight _____kg	Quantity Sufficient for 8 weeks	
<input type="checkbox"/> Rinvoq®	<input type="checkbox"/> 45mg tablet	Induction: Take 1 tablet orally once daily	#30	<input type="checkbox"/> 1 refill
	<input type="checkbox"/> 15mg tablet	Maintenance: Take 1 tablet orally once daily	#30	<input type="checkbox"/> 2 refills
	<input type="checkbox"/> 30mg 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.