## Crohn's/Ulcerative Colitis enrollment form





Patient information  Patient name  Address  City  Primary In  Prescriber information  Prescriber name  Group or hospital  Phone  Fax  Contact person name and insurant insura	NPI # City and phone	Alternate phor ZIP Height  DEA # State	Weight	
Patient name  Address  Gender: Male Female  Email  Prescriber information  Prescriber name  Group or hospital Phone  Fax  Contact person name  Clinical  Date of birth  City  Primary In  Primary In  Prescriber information:  State License #  Contact person name of the prescription and insurant insuran	State anguage  NPI # City and phone  nce card(s) with this	ZIP Height  DEA # State	Weight	
Patient name  Address  Gender: Male Female  Email  Prescriber information  Prescriber name  Group or hospital Phone  Fax  Contact person name  Clinical  Date of birth  City  Primary In  Primary In  Prescriber information:  State License #  Contact person name of the prescription and insurant insuran	State anguage  NPI # City and phone  nce card(s) with this	ZIP Height  DEA # State	Weight	
Address  Gender: Male Female  Email  Primary In  Prescriber information  Prescriber name  Group or hospital  Phone  Fax  Contact person name  Clinical  Date of diagnosis  Diagnosis ICD-10 code:  K50.90 Crohn's Disease K51.90 Ulcerative Colitis  Previous medications:  Current medicati	State anguage  NPI # City and phone  nce card(s) with this	ZIP Height  DEA # State	Weight	
Gender:       □ Male       □ Female       □ Primary Invariance         Prescriber information         Prescriber name       State License #         Group or hospital       Address         Phone       Fax       Contact person name and insurance information: If available, please fax a copy of the prescription and insurance information:         Clinical       Diagnosis ICD-10 code:       □ K51.90 Ulcerative Colitis         Previous medications:       Current medications	NPI # City and phone nce card(s) with this	DEA #	ZIP	
Prescriber information  Prescriber name  Group or hospital  Phone  Fax  Contact person name of the prescription and insurance information: If available, please fax a copy of the prescription and insurance information:  Clinical  Date of diagnosis  Diagnosis ICD-10 code:  K50.90 Crohn's Disease  Current medications:	NPI # City and phone nce card(s) with this	DEA #	ZIP	
Prescriber name  Group or hospital  Phone  Fax  Contact person name of the prescription and insurance information: If available, please fax a copy of the prescription and insurance information:  Clinical  Date of diagnosis  Diagnosis ICD-10 code:  K50.90 Crohn's Disease  K51.90 Ulcerative Colitis  Previous medications:  Current medications	City and phone nce card(s) with this	State		
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Group or hospital  Phone  Fax  Contact person name and insurance information: If available, please fax a copy of the prescription and insurance information: If available, please fax a copy of the prescription and insurance information:  Clinical  Date of diagnosis  Diagnosis ICD-10 code:  K50.90 Crohn's Disease  K51.90 Ulcerative Colitis  Previous medications:  Current medicati	City and phone nce card(s) with this	State		
Phone Fax Contact person name and Insurance information: If available, please fax a copy of the prescription and insurance information: If available, please fax a copy of the prescription and insurance information:  Clinical  Date of diagnosis  Diagnosis ICD-10 code:  K50.90 Crohn's Disease K51.90 Ulcerative Colitis  Previous medications:  Current medications	and phone  nce card(s) with this			
Insurance information: If available, please fax a copy of the prescription and insurance information: If available, please fax a copy of the prescription and insurance information:  Diagnosis ICD-10 code:  K51.90 Ulcerative Colitis  Previous medications:  Current medications	nce card(s) with this	form (front and bad	ck).	
Clinical         Date of diagnosis       Diagnosis ICD-10 code:         □ K50.90 Crohn's Disease       □ K51.90 Ulcerative Colitis         Previous medications:       Current medicati		form (front and bad	ck).	
Date of diagnosis       Diagnosis ICD-10 code:         □ K50.90 Crohn's Disease       □ K51.90 Ulcerative Colitis         Previous medications:       Current medicati	□ Other (ICD-10 Code			
Date of diagnosis       Diagnosis ICD-10 code:         □ K50.90 Crohn's Disease       □ K51.90 Ulcerative Colitis         Previous medications:       Current medicati	□ Other (ICD-10 Code			
□ K50.90 Crohn's Disease □ K51.90 Ulcerative Colitis  Previous medications: Current medicati	Other (ICD-10 Code			
		e)	_	
Does the patient have a latex allergy? Yes No Is the patient also	Current medications:			
	Is the patient also taking methotrexate? ☐ Yes ☐ No			
Does patient have active/serious infection? ☐ Yes ☐ No Allergies:	Allergies:			
Does patient have heart failure? ☐ Yes ☐ No				
Has patient had positive TB test? Yes No If yes, date of last chest x-ray				
Prescription information				
Medication Dose/strength Directions		Oua	ntity	Refill
	Directions		Starter Kit =	Keiiii
□ Cimzia®	☐ Induction Dose: Inject 400 mg SUBQ on day 1, 15, and 29		PFS PFS	0
L 200 mg/mL Prefilled Syringe	☐ Maintenance Dose: Inject 400 mg SUBQ every 28 days			
□ Dupixent® □ 300 mg/2 mL Pen □ Inject 300 mg SUBQ every 7 days	□ Inject 300 mg SUBQ every 7 days			
□ 300 mg/2 mL Prefilled Syringe				
☐ Maintenance Dose: Inject 108 mg SUBQ thereafter	☐ Maintenance Dose: Inject 108 mg SUBQ at week 6, followed by every 2 weeks thereafter			
If yes, date of IV induction doses:	Has the patient received the IV induction doses already? ☐ Yes ☐ No If yes, date of IV induction doses:  Week 0: Week 2:		☐ 2 Pens	

Ancillary supplies and kits will be provided as needed for administration.

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□ Humira®	Ulcerative Colitis Starter (6 pens)  40 mg/0.8 mL Prefilled Syringe Pediatric Crohn's Disease Starter (6 syringes)  40 mg/0.8 mL Prefilled Syringe Pediatric Crohn's Disease Starter (3 syringes)	<ul> <li>Adult Crohn's/UC and pediatric Crohn's ≥ 40 kg: Inject 160 mg SUBQ on day 1, 80 mg on day 15, then 40 mg every 14 days thereafter starting on day 29</li> <li>Pediatric Crohn's 17 to &lt; 40 kg: Inject 80 mg SUBQ on day 1, 40 mg on day 15, then 20 mg every 14 days starting on day 29</li> <li>Other:</li> </ul>	□1 Kit	0
	☐ 40 mg/0.8 mL Pen	The st 40 man SURO exempt 4 days		
	☐ 40 mg/0.8 mL Prefilled Syringe	☐ Inject 40 mg SUBQ every 14 days	☐ 2 Pens/PFS	
	☐ 20 mg/0.4 mL Prefilled Syringe	☐ Inject 40 mg SUBQ every 7 days	☐ 4 Pens/PFS	
	☐ 10 mg/0.2 mL Prefilled Syringe	Other:		
	Starter Dose  ☐ 80 mg/0.8 mL Pen Crohn's Disease,			
□ Humira® (Citrate-free)	Ulcerative Colitis Starter (3 pens)  40 mg/0.4 mL Pen Crohn's Disease, Ulcerative Colitis Starter (6 pens)  80 mg/0.8 mL Prefilled Syringe Pediatric Crohn's Disease Starter (3 syringes)  80 mg/0.8 mL and 40 mg/0.4 mL Prefilled Syringe Pediatric Crohn's Disease Starter (2 syringes)  80 mg/0.8 mL Pen Pediatric Ulcerative Colitis Starter (4 pens)  40 mg/0.4 mL Pen Pediatric Ulcerative Colitis (4 pens)  40 mg/0.4 mL Prefilled Syringe Pediatric Ulcerative Colitis (4 syringes)	<ul> <li>Adult Crohn's/UC and pediatric Crohn's ≥ 40 kg: Inject 160 mg SUBQ on day 1, 80 mg on day 15, then 40 mg every 14 days thereafter starting on day 29</li> <li>Pediatric Crohn's 17 to &lt; 40 kg: Inject 80 mg SUBQ on day 1, 40 mg on day 15, then 20 mg every 14 days starting on day 29</li> <li>Pediatric UC ≥ 40 kg: Inject 160 mg SUBQ on day 1, 80 mg on day 8, 80 mg on day 15, then begin maintenance dosing starting on day 29</li> <li>Pediatric UC 20 kg to &lt; 40 kg: Inject 80 mg SUBQ on day 1, 40 mg on day 8, 40 mg on day 15, then begin maintenance dosing starting on day 29</li> <li>Other:</li> </ul>	□ 1 Kit	0
	Maintenance Dose  □ 80 mg/0.8 mL CF Pen  □ 40 mg/0.4 mL CF Pen  □ 40 mg/0.4 mL CF Prefilled Syringe  □ 20 mg/0.2 mL CF Prefilled Syringe  □ 10 mg/0.1 mL CF Prefilled Syringe	☐ Inject 40 mg SUBQ every 14 days ☐ Inject 80 mg SUBQ every 14 days ☐ Inject 40 mg SQ every 7 days ☐ Other:	☐ 2 Pens/PFS ☐ 4 Pens/PFS	
□ Omvoh®	☐ 100 mg/mL Pen ☐ 100 mg/mL Prefilled Syringe	☐ Maintenance Dose: Inject 200 mg SUBQ at Week 12, followed by every 4 weeks thereafter  Has the patient received the IV induction doses already? ☐ Yes ☐ No If yes, date of IV induction doses:  Week 0: Week 4: Week 8:	2 Pens/PFS	
☐ Remicade®	□ 100 mg Vial	☐ Induction: Infusemg IV at weeks 0, 2, and 6	vial(s)	0
	L 100 mg viai	☐ Maintenance: Infusemg IV every 8 weeks	vial(s)	
	☐ 45 mg XR Tablet	☐ Take 1 tablet by mouth once daily	☐ 28 Tablets	
□ Rinvoq®	□ 15 mg XR Tablet □ 30 mg XR Tablet	☐ Take 1 tablet by mouth once daily	☐ 30 Tablets	
□ Simponi®	☐ 100 mg/mL Pen☐ 100 mg/mL Prefilled Syringe	☐ Induction Dose: Inject 200 mg SUBQ day 1, then 100 mg on day 15, then 100 mg every 28 days thereafter	☐ 3 Pens/PFS	0
	L 100 mg/mc Freimed Syringe	☐ Maintence Dose: Inject 100 mg SUBQ every 28 days	☐ 1 Pen/PFS	
Physician sign				

Physician signature required				
Product substitution permitted		Dispense as written		
X	Date	X	Date	

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☐ 40 mg/0.8 mL Pen Crohn's Disease,

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☐ 180 mg/1.2 mL prefilled cartridge with on-body injector	☐ Maintenance Dose: Inject 180 mg SUBQ at week 12, followed by every 8 weeks thereafter ☐ Maintenance Dose: Inject 360 mg SUBQ at week 12		
☐ 360 mg/2.4 mL prefilled cartridge with on-body injector	followed by every 8 weeks thereafter	□1 Kit	
	Has the patient received the IV induction doses already?		
90 mg Prefilled Syringe	☐ Maintenance Dose: Inject 90 mg SUBQ 8 weeks after initial IV dose, followed by every 8 weeks thereafter  Has the patient received the IV induction dose already? ☐ Yes ☐ No If yes, date of IV induction dose:	□1PFS	
☐ 100 mg/mL Pen ☐ 100 mg/mL Prefilled Syringe	☐ Maintenance Dose: Inject 100 mg SUBQ at week 16, followed by every 8 weeks thereafter ☐ Maintenance Dose: Inject 200 mg SUBQ at week 12, followed by every 4 weeks thereafter	□1 Pen/PFS	
☐ 200 mg/2 mL Pen☐ 200 mg/2 mL Prefilled Syringe	Has the patient received the IV induction doses already?		
☐ 2 mg Tablet	☐ Take 1 tablet by mouth once daily	□ 30	
☐ 10 mg Tablet	☐ Take 1 tablet by mouth 2 times daily	☐ 60 Tablets	
☐ 5 mg Tablet	☐ Take 1 tablet by mouth 2 times daily	☐ 60 Tablets	
	Other:		
☐ 22 mg XR Tablet	☐ Take 1 tablet by mouth once daily	☐ 30 Tablets	
☐ 11 mg XR Tablet	☐ Take 1 tablet by mouth once daily	☐ 30 Tablets	
☐ Titration Pack (7-day) ☐ Titration Pack (28-day)	☐ Titration Dose: 0.23 mg by mouth once daily on day 1-4, 0.46 mg once daily on day 5-7, followed by 0.92 mg once daily thereafter	☐ 1 Titration Kit	NA
□ 0.92 mg Capsule	☐ Take 1 tablet by mouth daily	☐ 30 Tablets	
☐ 120 mg/mL Pen☐ 120 mg/mL Prefilled Syringe	☐ Maintenance Dose: Inject 120 mg SUBQ at week 10, followed by every 2 weeks thereafter  Has the patient received the IV induction doses already? ☐ Yes ☐ No If yes, date of IV induction doses:  Week 0: Week 2: Week 6:	□ 2 Pens/PFS	
	with on-body injector    360 mg/2.4 mL prefilled cartridge with on-body injector    90 mg Prefilled Syringe    100 mg/mL Pen	with on-body injector    Gollowed by every 8 weeks thereafter   Maintenance Dose: Inject 360 mg SUBQ at week 12, followed by every 8 weeks thereafter   Maintenance Dose: Inject 360 mg SUBQ at week 12, followed by every 8 weeks thereafter   Has the patient received the IV induction doses already?   Yes   No If yes, date of IV induction doses: Week 0:   Week 4:   Week 8:     Week 8:     Week 8:     Week 8:     Week 9:   Week	Maintenance Dose: Inject 200 mg SUBQ at week 12, followed by every 8 weeks thereafter     1 Kit

Physician signature required				
Product substitution permitted		Dispense as written		
X	Date	X	Date	

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