Crohn's/Ulcerative Colitis
enrollment form

Phone: 855-425-4085 **Fax:** 855-425-4096 **ardonhealth.com**

Date needed	Medication start date	Ship to: ☐ Patient ☐ Physician ☐ Other:

Patient information

Patient name	Date of birth		Phone	Alternate phone	
Address		City	State	ZIP	
Gender: ☐ Male ☐ Female	Email	Primary language		Height	Weight

Prescriber information

Prescriber name	State License #	NPI #	DEA #	
Group or hospital	Address	City	State	ZIP
Phone	Fax	Contact person name and phone		

Insurance information: If available, please fax a copy of the prescription and insurance card(s) with this form (front and back).

Clinical

Date of diagnosis	Diagnosis ICD-10 code: ☐ K50.90 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other (ICD-10 Code) _____
Previous medications:	Current medications:
Does the patient have a latex allergy? ☐ Yes ☐ No	Is the patient also taking methotrexate? ☐ Yes ☐ No
Does patient have active/serious infection? ☐ Yes ☐ No	Allergies:
Does patient have heart failure? ☐ Yes ☐ No	Is the patient new to therapy? ☐ Yes ☐ No
Has patient had positive TB test? ☐ Yes ☐ No *If yes, date of last chest x-ray* _____	

Prescription information

Medication	Dose/strength	Directions	Quantity	Refill
☐ Cimzia®	☐ Starter Kit	☐ Induction Dose: Inject 400 mg SUBQ on day 1, 15, and 29	☐ 1 Starter Kit = 6 PFS	0
	☐ 200 mg/mL Prefilled Syringe ☐ 200 mg Vial	☐ Maintenance Dose: Inject 400 mg SUBQ every 28 days	☐ 2 PFS/Vials	
☐ Dupixent®	☐ 300 mg/2 mL Pen ☐ 300 mg/2 mL Prefilled Syringe	☐ Inject 300 mg SUBQ every 7 days	☐ 4 Pens/PFS	
☐ Entyvio®	☐ 108 mg/0.6 mL Pen	☐ Maintenance Dose: Inject 108 mg SUBQ at week 6, 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: _____	☐ 2 Pens	

Physician signature required

Product substitution permitted	**Dispense as written**
X _____ Date _____	X _____ Date _____

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

☐ Humira®	☐ 40 mg/0.8 mL Pen Crohn's Disease, 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)	☐ 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 ☐ Pediatric Crohn's 17 to < 40 kg: Inject 80 mg SUBQ on day 1, 40 mg on day 15, then 20 mg every 14 days starting on day 29 ☐ Other: _____	☐ 1 Kit	0
	☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.8 mL Prefilled Syringe ☐ 20 mg/0.4 mL Prefilled Syringe ☐ 10 mg/0.2 mL Prefilled Syringe	☐ Inject 40 mg SUBQ every 14 days ☐ Inject 40 mg SUBQ every 7 days ☐ Other: _____	☐ 2 Pens/PFS ☐ 4 Pens/PFS	
☐ Humira® (Citrate-free)	**Starter Dose** ☐ 80 mg/0.8 mL Pen Crohn's Disease, 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)	☐ 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 ☐ Pediatric Crohn's 17 to < 40 kg: Inject 80 mg SUBQ on day 1, 40 mg on day 15, then 20 mg every 14 days starting on day 29 ☐ 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 ☐ Pediatric UC 20 kg to < 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 ☐ Other: _____	☐ 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: Infuse _____mg IV at weeks 0, 2, and 6	_____ vial(s)	0
		☐ Maintenance: Infuse _____mg IV every 8 weeks	_____ vial(s)	
☐ Rinvoq®	☐ 45 mg XR Tablet	☐ Take 1 tablet by mouth once daily	☐ 28 Tablets	
	☐ 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
		☐ Maintence Dose: Inject 100 mg SUBQ every 28 days	☐ 1 Pen/PFS	

Physician signature required

Product substitution permitted	**Dispense as written**
X _____ Date _____	X _____ Date _____

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☐ Skyrizi®	☐ 180 mg/1.2 mL prefilled cartridge with on-body injector ☐ 360 mg/2.4 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, 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: _____	☐ 1 Kit	
☐ Stelara®	☐ 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:* _____	☐ 1 PFS	
☐ Tremfya®	☐ 100 mg/mL Pen ☐ 100 mg/mL Prefilled Syringe ☐ 200 mg/2 mL Pen ☐ 200 mg/2 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 Has the patient received the IV induction doses already? ☐ Yes ☐ No *If yes, date of IV induction doses:* Week 0: _____ Week 4: _____ Week 8: _____	☐ 1 Pen/PFS	
☐ Velsipity®	☐ 2 mg Tablet	☐ Take 1 tablet by mouth once daily	☐ 30	
☐ Xeljanz®	☐ 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	
☐ Zeposia®	☐ 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	
☐ Zymfentra®	☐ 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	

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

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