Crohn's/Ulcerative Colitis Enrollment Form

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

PATIENT INFORMATION

Patient Name:
Address:
City: State: Zip:
Primary Phone: DOB:
Alternate Phone: Gender: ☐ Male ☐ Female
Email:
Primary Language:
Height: Weight:

PRESCRIBER INFORMATION

Prescriber's Name:
State License #: NPI #:
DEA #:
Group or Hospital:
Address:
City: State: Zip:
Phone: Fax:
Contact Person: Phone:

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL

Need By Date:	**Ship to**: ☐ Patient ☐ Physician ☐ Other:
Date of Diagnosis:	**Diagnosis ICD-10 Code: Crohn's Disease** ☐ K50.90 **Ulcerative Colitis** ☐ K51.90 **Other (ICD-10 Code)** ☐ ________________

Previous Failed Medications:

Current Medications:

Allergies: **Latex Allergy?** ☐ Yes ☐ No

Does patient have Active/Serious Infection? ☐Yes ☐ No **Does patient have Heart Failure?** ☐ Yes ☐ No

Has patient had a positive TB test? ☐ **Yes** ☐ **No** If Yes, Date of last Chest X-Ray: **Is the patient new to therapy?** ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Cimzia®	☐ Starter Kit ☐ 200mg/mL PFS ☐ 200mg Vial	☐ **Induction Dose**: Inject 400mg SQ on day 1, 15, and 29 ☐ **Maintenance Dose**: Inject 400mg SQ every 4 weeks	☐ 1 Starter Kit = 6 PFS ☐ 2	_____
☐ Humira® (Citrate-free)	**Starter Dose** ☐ 40mg/0.4mL Pen Crohn's Disease, Ulcerative Colitis, Hidradenitis Starter (6 pens) ☐ 80mg/0.8mL Pen Crohn's Disease, Ulcerative Colitis, Hidradenitis Starter (3 pens) ☐ 80mg/0.8mL Prefilled Syringe Pediatric Crohn's Disease Starter (3 syringes – for peds ≥ 40 kg) ☐ 80mg/0.8mL and 40mg/0.4mL Prefilled Syringe Pediatric Crohn's Disease Starter (2 syringes – for peds 17 kg to < 40 kg)	☐ Adult Crohn's/UC and pediatric Crohn's ≥ 40 kg: Inject 160mg SQ on day 1, 80mg SQ on day 15, then 40mg SQ every 14 days thereafter starting on day 29 ☐ Pediatric Crohn's 17 to < 40 kg: Inject 80mg SQ on day 1, 40mg SQ on day 15, then 20mg SQ every 14 days starting on day 29 ☐ Other: ______________________	☐ 1 kit	0
	Maintenance Dose ☐ 40mg/0.4mL CF Pen ☐ 40mg/0.4mL CF Prefilled Syringe ☐ 20mg/0.2mL CF Prefilled Syringe ☐ 10mg/0.1mL CF Prefilled Syringe	☐ Inject 40mg SQ every OTHER week ☐ Inject 40mg SQ every week ☐ Other: ______________________	☐ 2 pens/PFS ☐ 4 pens/PFS	_____

PHYSICIAN SIGNATURE REQUIRED

X ______________________________ (Date)
PRODUCT SUBSTITUTION PERMITTED
Ancillary supplies and kits will be provided as needed for administration.

X ______________________________ (Date)
DISPENSE AS WRITTEN

Date Needed: ____________ Medication Start Date: ____________

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	☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL Prefilled Syringe ☐ 20mg/0.4mL Prefilled Syringe ☐ 10mg/0.2mL Prefilled Syringe	☐ Inject 40mg SQ every OTHER week ☐ Inject 40mg SQ every week ☐ Other: ______________________________	☐ 2 pens/PFS ☐ 4 pens/PFS	_____
☐ Simponi®	☐ 100mg/mL SmartJect ☐ 100mg/mL PFS	☐ **Induction Dose**: Inject 200mg SQ day 1, then 100mg SQ on day 15, then 100mg every 4 weeks thereafter ☐ **Maintence Dose:** Inject 100mg SQ every 28 days ☐ Other: ______________________________	☐ 3 x 100mg Pens/PFS ☐ 1 x 100mg Pens/PFS	_____
☐ Stelara®	☐ 90mg PFS	☐ **Maintenance Dose:** Inject _____mg SQ every 56 days	☐ 1 PFS	_____
☐ Remicade®	☐ 100mg Vial	☐ Induction: Infuse _____mg IV at weeks 0, 2, and 6 ☐ Maintenance: Infuse _____mg IV very 8 weeks	☐ _____ # Vial(s)	_____
☐ Xeljanz®	☐ 5mg Tab ☐ 10mg Tab ☐ 11mg XR Tab ☐ 22mg XR Tab	☐ Take one 5mg tablet PO twice daily ☐ Take one 10mg tablet PO twice daily ☐ Take one 11mg XR tablet PO once daily ☐ Take one 22mg XR tablet PO once daily ☐ Other: ______________________________	☐ 60 ☐ 30	_____

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X ______________________________ (Date)
PRODUCT SUBSTITUTION PERMITTED

X ______________________________ (Date)
DISPENSE AS WRITTEN

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

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