ardon

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 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 ☐ 200 mg/mL Prefilled Syringe ☐ 200 mg Vial	☐ Induction Dose: Inject 400 mg SUBQ on day 1, 15, and 29 ☐ Maintenance Dose: Inject 400 mg SUBQ every 28 days	☐ 1 Starter Kit = 6 PFS ☐ 2 PFS/Vials	0 _____
☐ 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	_____

X _____ **X** _____

PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

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

Date Needed: _____ Medication Start Date: _____

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PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ 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	_____
☐ 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	_____
☐ 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	_____
☐ 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 (37-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
	☐ 0.92mg Capsule	☐ Take 1 tablet by mouth daily	☐ 30 Tablets	____

X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED

X _____ (Date)
DISPENSE AS WRITTEN

PHYSICIAN SIGNATURE REQUIRED

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

Date Needed: _____ Medication Start Date: _____

This prescription is valid only if transmitted by facsimile machine by a licensed provider.