Crohn's/Ulcerative Colitis Enrollment Form

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

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Patient Name:				Prescriber's Name:			
Address:				State License #:		NPI #:	
City:		State:	Zip:	DEA #:			
Primary Phone:		DOB:		Group or Hospital:			
Alternate Phone:		Gender:	☐ Male ☐ Female	Address:			
Email:				City:		State:	Zip:
Primary Language:				Phone:		Fax:	
Height:		Weight:		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 ☐ 200mg/mL PFS ☐ 200mg Vial	☐ **Induction Dose**: Inject 400mg SQ on day 1, 15, and 29	☐ 1 Starter Kit = 6 PFS	0
		☐ **Maintenance Dose**: Inject 400mg SQ every 4 weeks	☐ 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) ☐ 80mg/0.8mL Pen Pediatric Ulcerative Colitis Starter (4 pens - for peds ≥ 40 kg) ☐ 40mg/0.4 mL Pen Pediatric Ulcerative Colitis (4 pens - for peds 20 kg to < 40 kg) ☐ 40 mg/0.4 mL Prefilled Syringe Pediatric Ulcerative Colitis (4 syringes - for peds 20 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 ☐ Pediatric UC ≥ 40 kg: Inject 160mg SQ on day 1, 80mg SQ on day 8, 80mg SQ on day 15, then begin maintenance dosing starting on day 29 ☐ Pediatric UC 20 kg to < 40 kg: Inject 80mg SQ on day 1, 40mg SQ on day 8, 40mg SQ on day 15, then begin maintenance dosing starting on day 29 ☐ Other: ______________________________	☐ 1 Kit	0
	Maintenance Dose ☐ 80mg/0.8mL CF Pen ☐ 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 80mg 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: ______________

The information included in this FAX is intended for the sole use of the individual to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended addressee, nor authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose or distribute this information. If you have received this FAX in error, please contact the sender and destroy the entire document. 0125 (4/22)

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

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MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Humira®	☐ 40mg/0.8mL Pen Crohn's Disease, Ulcerative Colitis, Hidradenitis Starter (6 pens) ☐ 40mg/0.8mL Prefilled Syringe Pediatric Crohn's Disease Starter (6 syringes) ☐ 40mg/0.8mL Prefilled Syringe Pediatric Crohn's Disease Starter (3 syringes)	☐ 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
	☐ 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	_____
☐ Remicade®	☐ 100mg Vial	☐ Induction: Infuse _____mg IV at weeks 0, 2, and 6 ☐ Maintenance: Infuse _____mg IV very 8 weeks	☐ _____ # Vial(s)	_____
☐ Rinvoq®	☐ 45mg XR Tab	☐ Take one 45mg tablet PO once daily	☐ 28	_____
	☐ 15mg XR Tab	☐ Take one 15mg tablet PO once daily	☐ 30	_____
	☐ 30mg XR Tab	☐ Take one 30mg tablet PO once daily		
☐ 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	☐ 3 Pens/PFS	0
		☐ **Maintence Dose:** Inject 100mg SQ every 28 days ☐ Other: ______________________________	☐ 1 Pens/PFS	_____
☐ Stelara®	☐ 90mg PFS	☐ **Maintenance Dose:** Inject 90mg SQ every 56 days Has the patient received the IV induction dose already? ☐ Yes ☐ No If Yes, date of IV induction dose:______________________	☐ 1 PFS	_____
☐ Xeljanz®	☐ 10mg Tab	☐ Take one 10mg tablet PO twice daily	☐ 60	_____
	☐ 22mg XR Tab	☐ Take one 22mg XR tablet PO once daily	☐ 30	
	☐ 5mg Tab	☐ Take one 5mg tablet PO twice daily	☐ 60	_____
	☐ 11mg XR Tab	☐ Take one 11mg XR tablet PO once daily	☐ 30	
☐ Zeposia	☐ Titration Pack (7-day) ☐ Titration Pack (37-day) ☐ 0.92mg Cap	☐ **Titration Dose**: 0.23mg PO day 1-4, 0.46mg day 5-7, followed by 0.92mg daily thereafter	☐ 1 Titration Kit	NA
		☐ Take 0.92mg PO daily	☐ 30	____

PHYSICIAN SIGNATURE REQUIRED

X ____ ______________
PRODUCT SUBSTITUTION PERMITTED (Date)

X ____ DISPENSE AS WRITTEN (Date)

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

Date Needed: ______________ Medication Start Date: ______________

The information included in this FAX is intended for the sole use of the individual to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended addressee, nor authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose or distribute this information. If you have received this FAX in error, please contact the sender and destroy the entire document. 0125 (4/22)