Crohn's Disease Enrollment Form

PATIENT INFORMATION

Patient Name: ____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: ____
City: _____________ State: _____ Zip: _______________

Phone: (____) - ____ - ________
email: ____
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: ____ /____ / ____
Allergies: Medications: Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: __________________ ID#: ________________________ Group #: ______________ RxBIN: _________ RxPCN: _________

PRESCRIBER INFORMATION

Prescriber Name: ________________________________
Address: ____________________________________
City: ____________ State: _____ Zip: ______________
Contact: _______________________
Clinic/Hospital Affiliation: ___________________________

Phone: (____) - ____ - ________
Fax: (____) - ____ - ________
License #: _______________________
NPI #: _______________________
Medicaid Provider #: _______________________

CDRX-17-02

CLINICAL CONSIDERATIONS

Diagnosis:
☐ K50.0 Crohn's disease of the small intestine without complications
☐ K50.8 Crohn's disease of both intestines
☐ K50.1 Crohn's disease of the large intestine
☐ K50.9 Crohn's disease, unspecified
☐ Other: _____________

TB Test Completed: ☐ Yes ☐ No
Date of negative test: ____ /____ / ____
If history of latent TB, has patient received treatment?
☐ Yes ☐ No
Please list previously tried/failed therapies & dates:

Immunization History
☐ Influenza:___ /___ / ___

Hep B Screening:
☐ Positive ☐ Negative
Date: ____ /____ / ____

Medication	Dose/Strength	Directions	Quantity	Refills
Cimzia® (certolizumab pegol)	**Initial Dose** ☐ Cimzia Starter Kit	☐ Inject 400 mg subcutaneously (two 200 mg injections) at weeks 0, 2, and 4, then maintenance dose	1 kit (six 200 mg prefilled syringes)	0
	Maintenance Dose ☐ 200 mg prefilled syringe ☐ 200 mg vial	☐ Inject 400 mg subcutaneously (two 200 mg injections) every 4 weeks		
Entyvio® (vedolizumab)	☐ 300 mg vial	☐ Infuse 300 mg IV over 30 minutes at 0, 2, and 6 weeks, then every 8 weeks thereafter		
Humira® (adalimumab)	**Initial Dose** ☐ Crohn's/Ulcerative Colitis Starter Package	☐ Inject 160 mg subcutaneously (four 40 mg pens) on day 1, then 80 mg (two 40 mg pens) on day 15, then maintenance dose ☐ Inject 80 mg subcutaneously (two 40 mg pens) over 2 consecutive days, then 80 mg (two 40 mg pens) on day 15, then maintenance dose	1 package (six 40 mg pens)	0
	Maintenance Dose ☐ 40 mg pen ☐ 40 mg prefilled syringe	☐ Inject 40 mg subcutaneously every other week		
Inflectra® (infliximab-dyyb)	☐ 100 mg vial *Patient Dosing Weight:* _____kg	☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose ☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks ☐ Other: _____________		
Remicade® (infliximab)	☐ 100 mg vial *Patient Dosing Weight:* _____kg	☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose ☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks ☐ Other: _____________		
Renflexis™ (infliximab-abda)	☐ 100 mg vial *Patient Dosing Weight:* _____kg	☐ **Initial Dose**: 5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose ☐ **Maintenance Dose**: 5 mg/kg IV every 8 weeks ☐ Other: _____________		
Stelara® (ustekinumab)	**Maintenance Dose** ☐ 90 mg prefilled syringe	☐ Inject 90 mg subcutaneously every 8 weeks; begin maintenance dose 8 weeks after the IV induction dose ☐ Other: _____________		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: __________________

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: ______________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

PANTHERx SPECIALTY PHARMACY **PHONE**: 855-726-8479 (412-246-9858) **FAX**: 855-246-3986 (412-787-9400) **www.pantherspecialty.com**

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