

Crohn's Disease/Ulcerative Colitis Enrollment Form

Ph: 806-324-5447 • Toll Free 866-629-6779
 Toll Free Fax: 866-217-8034
 Email: specialty@maxor.com
www.maxorspecialty.com



PATIENT INFORMATION		PHYSICIAN INFORMATION			
Patient Name _____ Date of Birth _____ <input type="radio"/> Male <input type="radio"/> Female Street Address _____ Apt # _____ City _____ State _____ Zip _____ Phone-Primary _____ Secondary _____ <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____ Email Address _____ Social Security # _____ <input type="radio"/> NKDA Known Drug Allergies _____ Weight _____ kg/lb Height _____ in/cm <p style="text-align: center; color: blue;">Please attach front and back of patient's insurance cards</p>		Physician Name _____ NPI _____ License # _____ Office Contact _____ Street Address _____ Ste # _____ City _____ State _____ Zip _____ Phone _____ Fax _____ By signing this form, I authorize Maxor Specialty to act as my agent for prior authorizations & prescription reimbursement for the above listed patient. Physician Signature _____ Date _____ <input type="radio"/> Dispense as written <input type="radio"/> Product substitution permitted <p style="text-align: center;">** For Ohio patients, please only choose one (1) prescription/form.**</p>			
CLINICAL INFORMATION					
Diagnosis Code: <input type="radio"/> K50.90 Crohn's Disease <input type="radio"/> K51.80 Ulcerative Colitis <input type="radio"/> Other: _____ History: Has the Patient been treated previously for this condition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NSAIDS Duration: _____ <input type="radio"/> Sulfasalazine Duration: _____ <input type="radio"/> Corticosteroid Duration: _____ <input type="radio"/> MTX Duration: _____ <input type="radio"/> 5-ASA(5-Aminosalicylates) Duration: _____ <input type="radio"/> 6-MP(6-Mercaptopurin) Duration: _____ <input type="radio"/> Biologics Duration: _____ <input type="radio"/> Azathioprine Duration: _____ <input type="radio"/> Other Duration: _____ Is the Patient currently on therapy? <input type="radio"/> Yes <input type="radio"/> No List Meds: _____ Will patient stop taking Meds before starting new Meds? <input type="radio"/> Yes <input type="radio"/> No How long will patient wait before starting new meds? _____ Other Meds Patient is on: _____ Has patient received PPD (skin test)? <input type="radio"/> Yes <input type="radio"/> No Results: _____ Additional medical rationale for treatment: <input type="radio"/> No response to previous treatment <input type="radio"/> Contraindications to treatments _____ <input type="radio"/> Side effects, lab abnormalities, toxicity with treatments <input type="radio"/> Other _____					
PRESCRIPTION INFORMATION		CHECK TO ENROLL IN PATIENT ASSISTANCE PROGRAM <input type="radio"/>			
MEDICATION	STRENGTH	DIRECTIONS		QTY	REFILLS
<input type="radio"/> Cimzia® (Crohn's Indication)	<input type="radio"/> Starter Kit 200mg (6 PFS) <input type="radio"/> 200mg (2 PFS)	Initial Dose: <input type="radio"/> Inject 400mg SQ on day 0, 2, 4 Maintenance Dose: <input type="radio"/> Inject 400mg SQ every 4 wks			
<input type="radio"/> Entyvio®	300mg Vial	Initial Dose: <input type="radio"/> Infuse 300mg IV over 30 min @ wk 0,2,6 Maintenance Dose: <input type="radio"/> Infuse 300mg IV over 30 min every 8 wks			
<input type="radio"/> Humira® (Crohn's & Ulcerative Colitis Indication)	<input type="radio"/> Starter Kit <input type="radio"/> 40mg Pen X 2 <input type="radio"/> 40mg PFS X 2	Initial Dose: 160mg given as: <input type="radio"/> Four 40mg SQ day 1 "OR" <input type="radio"/> Two 40mg SQ days 1 & 2 then inject 80mg (two 40mg) SQ on day 15 Maintenance Dose: <input type="radio"/> Inject 40mg SQ every other wk			
<input type="radio"/> Remicade® (Crohn's & Ulcerative Colitis Indication)	100mg Vial	Initial Dose: Infuse Remicade in NS 250ml over 2 hrs as directed <input type="radio"/> 5mg/kg IV @ 0, 2, & 6wks Maintenance Dose: <input type="radio"/> 5mg/kg IV every 8 wks			
<input type="radio"/> Simponi® (Ulcerative Colitis Indication)	100mg Pen	Initial Dose: <input type="radio"/> 200mg SQ @ wk 0, 100mg @ wk 2 Maintenance Dose: <input type="radio"/> 100 mg SQ every 4 wks starting @ wk 6			
<input type="radio"/> Other					
Date meds needed: _____ <input type="radio"/> New <input type="radio"/> Refill Ship to: <input type="radio"/> Patient's home <input type="radio"/> Physician's Office <input type="radio"/> Other _____					

CONFIDENTIALITY NOTICE: This communication is intended for and should be delivered to the individual or entity to which it is addressed and contains information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this information. Please notify the sender immediately if you have received this document in error.