Crohn's Disease/Ulcerative Colitis Enrollment Form

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Maxor SPECIALTY PHARMACY

PATIENT INFORMATION

Patient Name _____
Date of Birth _____ ◯ Male ◯ Female
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Phone-Primary _____ Secondary _____
◯ English ◯ Spanish ◯ Other _____
Email Address _____
Social Security # _____
◯ NKDA Known Drug Allergies _____
Weight _____ kg/lb Height _____ in/cm

Please attach front and back of patient's insurance cards

PHYSICIAN INFORMATION

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 _____

◯ Dispense as written ◯ Product substitution permitted

** For Ohio patients, please only choose one (1) prescription/form.**

CLINICAL INFORMATION

Diagnosis Code: ◯ K50.90 Crohn's Disease ◯ K51.80 Ulcerative Colitis ◯ Other: _____

History: Has the Patient been treated previously for this condition? ◯ Yes ◯ No

◯ NSAIDS Duration: _____ ◯ Sulfasalazine Duration: _____ ◯ Corticosteriod Duration: _____
◯ MTX Duration: _____ ◯ 5-ASA(5-Aminosalicylates) Duration: _____ ◯ 6-MP(6-Mercaptopurin) Duration: _____
◯ Biologics Duration: _____ ◯ Azathioprine Duration: _____ ◯ Other Duration: _____

Is the Patient currently on therapy? ◯ Yes ◯ No List Meds: _____

Will patient stop taking Meds before starting new Meds? ◯ Yes ◯ No How long will patient wait before starting new meds? _____

Other Meds Patient is on: _____

Has patient received PPD (skin test)? ◯ Yes ◯ No Results: _____

Additional medical rationale for treatment:

◯ No response to previous treatment _____ ◯ Contraindisctions to treatments _____
◯ Side effects, lab abnormalities, toxicity with treatments _____ ◯ Other _____

PRESCRIPTION INFORMATION

CHECK TO ENROLL IN PATIENT ASSISTANCE PROGRAM ◯

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
◯ **Cimzia® (Crohn's Indication)**	◯ Starter Kit 200mg (6 PFS) ◯ 200mg (2 PFS)	**Initial Dose:** ◯ Inject 400mg SQ on day 0, 2, 4 **Maintenance Dose:** ◯ Inject 400mg SQ every 4 wks		
◯ **Entyvio®**	300mg Vial	**Initial Dose:** ◯ Infuse 300mg IV over 30 min @ wk 0,2,6 **Maintenance Dose:** ◯ Infuse 300mg IV over 30 min every 8 wks		
◯ **Humira® (Crohn's & Ulcerative Colitis Indication)**	◯ Starter Kit ◯ 40mg Pen X 2 ◯ 40mg PFS X 2	**Initial Dose:** 160mg given as: ◯ Four 40mg SQ day 1 "OR" ◯ Two 40mg SQ days 1 & 2 then inject 80mg (two 40mg) SQ on day 15 **Maintenance Dose:** ◯ Inject 40mg SQ every other wk		
◯ **Remicade® (Crohn's & Ulcerative Colitis Indication)**	100mg Vial	**Initial Dose**: Infuse Remicade in NS 250ml over 2 hrs as directed ◯ 5mg/kg IV @ 0, 2, & 6wks **Maintenance Dose:** ◯ 5mg/kg IV every 8 wks		
◯ **Simponi® (Ulcerative Colitis Indication)**	100mg Pen	**Initial Dose:** ◯ 200mg SQ @ wk 0, 100mg @ wk 2 **Maintenance Dose:** ◯ 100 mg SQ every 4 wks starting @ wk 6		
◯ **Other**				

Date meds needed: _____ ◯ New ◯ Refill

Ship to: ◯ Patient's home ◯ Physician's Office ◯ Other _____