Crohn's Disease

PRESCRIPTION & ENROLLMENT FORM

❑ New Patient
❑ Current

❶ PATIENT INFORMATION

Patient's Name ______________________________
Date of Birth ____________ ❑ Male ❑ Female
Street Address ______________________ Apt# ____________
City ______________________ State ________ Zip __________
Parent/Guardian (if applicable) ______________________
Home Phone ________________ Work Phone ________________
Cell Phone ________________ Evening Phone ________________
E-mail address ______________________________
Insurance Company Name ______________________
Insurance Company Phone No. ______________________
Insured's Name ______________________________
Relationship to Patient ______________________
Identification No. ________________ Policy/Group No. ________________
Prescription Card ❑ No ❑ Yes If Yes, Carrier ________________
Policy No. ________________ Group No. ________________
Is patient eligible for Medicare? ❑ No ❑ Yes **Please attach front and back copy of patient's insurance cards, if available.**

❷ PRESCRIBER INFORMATION

Prescriber's Name ______________________________
Office Contact ______________________ Office hours: __________
Clinic / Hospital Affiliation ______________________
Street Address ______________________ Suite # __________
City ______________________ State ________ Zip __________
Phone ________________ Fax ________________
NPI No. ________________ License No. ________________
DEA No. ______________________________
Physician Medicaid UPIN No. ______________________
MD Specialty ______________________________

To reach your team, call toll-free 1.866.489.1899.

Please fax completed form to the Crohn's team 1.866.489.1901.

CRO-050908-1

❸ CLINICAL INFORMATION

ICD9 CODE ______________________________

Current Weight ________ kg Height ________ inches/cm BSA ________m^2
________ lbs

Rx:

❑ **Cimzia**

- ❑ Initial dose of 400 mg SC at week 0, week 2, and week 4 followed by:
- ❑ Maintenance dose of 400 mg SC every 4 weeks
- ❑ Other: ______________________________

❑ **Humira**

Initial Dose:

❑ Inject 160 mg subcutaneously on day 1, 80 mg on day 15, then 40 mg every other week. (Per Humira starter kit)

Maintenance Dose:

❑ Inject 40 mg subcutaneously every other week.

❑ Humira 40 mg/ 0.8mL PFS ❑ Humira 40 mg/ 0.8mLPens

❑ **Remicade**

❑ Infuse Remicade in NS 250 mL over 2 hours as directed

❑ 5 mg per kg ❑ 3 mg per kg @ 0,2 & 6 weeks ❑ 3 mg per kg every 8 weeks

SIG: Dose: ________________

Directions (Include daily, weekly, cyclic, one-time, duration of therapy, etc.)
____
____

Quantity: ______________________ Refills: __________

❑ NKDA ❑ Known Drug Allergies: ______________________

EXPECTED DATE OF FIRST/NEXT DOSE: __________ Date of Last Dose? __________

Deliver product to: ❑ Office ❑ Patient's Home ❑ Clinic
Clinic Location ______________________________
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name ______________________

Prescriber's Signature (sign below) **Date** ______________

______________________ ______________________
Dispense as Written **Substitution Allowed**

(Physician attests this is his/her legal signature. **NO STAMPS)**