Bell Pharmacy

Crohn's & Ulcerative Colitis Enrollment Form

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PATIENT INFORMATION

Name:	Date of Birth:		O Male O Female
Address:	City:	State:	Zip:
Phone:	Alt Phone:		Email:
SS #:	Primary Language:		Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

PRESCRIPTION INFORMATION

Needs by Date: Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other

Drug	Dose	Direction & Quantities	Refills
O Cimzia	O Pre-filled Syringe O Vials	O INITIAL: Inject 400 mg subcutaneously on day 1, 14, and 28 (Qty: 6) O MAINTENANCE: Inject 400 mg subcutaneously every 4 weeks (Qty: 2)	
O Entyvio	O Vials	O INITIAL: Infuse 300 mg intravenously over 30 minutes at Day 0, 14, and 42 (Qty: 3) O MAINTENANCE: Infuse 300 mg intravenously over 30 minutes every 8 weeks after the Initial dosage is completed (Qty: 1)	
O Humira O Humira CF	O Crohn's Starter Kit O Pen O Pre-filled Syringe	O INITIAL: Inject 160 mg subcutaneously on day 1, then 80 mg on day 14 (1 Kit) O MAINTENANCE: Inject 40 mg subcutaneously every other week (Qty: 2)	
O Inflectra O Remicade O Renflexis	O Vials	O INITIAL: Infuse __________mg on day 0, 14, and 42 (Qty: ______) O MAINTENANCE: Infuse ___________mg every 8 weeks (Qty: ______)	
O Simponi	O SmartJect® (Pen) O Pre-filled Syringe	O INITIAL: Inject 200 mg subcutaneously on day 1, then 100 mg on day 14 (Qty: 3) O MAINTENANCE: Inject 100 mg subcutaneously every 4 weeks (Qty: 1)	
O Stelara	O 130mg/26mL Vials O Pre-filled Syringe 90mg O Vials 45 mg	O Initial Adult Intravenous Dosage: A single intravenous infusion using weight-based dosing: Up to 55kg=260 mg (2 Vials), 55kg to 85kg = 390 mg (3 Vials), >85kg=520 mg (4 Vials) O MAINTENANCE: Inject subcutaneously 90 mg 8 weeks after initial dose, then every 8 weeks thereafter (1 Syringe)	
O Xeljanz	O 5 mg O 10 mg	O INITIAL: 10 mg twice daily for at least 8 weeks O MAI NTENANCE: 5 to 10 mg twice daily. Discontinue after 16 weeks of 10 mg twice daily, if adequate therapeutic benefit is not achieved. Use the lowest effective dose to maintain response.	

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

Date of Diagnosis: _______/_______/_______

O K50.00 Crohn's Disease of the Small Intestine without Complications

O K50.10 Crohn's Disease of the Large Intestine without Complications

O K50.80 Crohn's Disease of Both Intestines without Complications

O K50.90 Crohn's Disease Unspecified without Complications

O K51.50 Left-sided Ulcerative Colitis without Complications

O K51.80 Other Ulcerative Colitis without Complications

O K51.90 Ulcerative Colitis, Unspecified without Complications

O Other: ____

Other:

O Patient is steroid dependent

O Other: ____________________________________

Allergies: ____________________________________

Active TB is ruled out: O Yes O No

Date: _______/_______/_______

Hep B is ruled out / treated: O Yes O No

Date: _______/_______/_______

Patient Height:_______________________ in/cm Weight: _______________________ kg/lbs

INJECTION TRAINING

O Patient has received pen and injection training | O Physician's office to provide injection training | O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Faxed Prescriptions will only be accepted from a prescribing practitioner.