elixir SPECIALTY PHARMACY

Ulcerative Colitis Enrollment Form

Phone: (877) 437-9012 Fax: (877) 309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: ______________________
Date of Birth: ________ Sex: ______ Caregiver: ______________
Address: ______________________
City: ______________ State: ______ Zip: ______________
Home Phone: ______________ Work Phone: ______________
Cell Phone: ______________ E-mail: ______________
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: ______________________
Insurance Company Phone: ______________________
Policy holder: ______________________
Policy holder Employer: ______________________
Relationship to Patient: ______________________
ID# ______________ Group# ______________
RxBIN: ______________ RxPCN: ______________

Prescriber Information

Practice/Organization Name: ______________________
Physician Name: ______________________
Address: ______________________
City: ______________ State: ______________ Zip: __________
Phone#: ______________ Fax#: ______________
DEA# ______________ NPI# ______________
License#: ______________ Medicaid UPIN#: ______________
Physician Specialty: ______________________
Date Shipment Needed: ______________________
Ship to: ☐**Patient** ☐**Prescriber** ☐**Infusion Clinic**
Shipment Address: ______________ Attn: ______________
City: ______________ State: ______________ Zip: __________
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

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Clinical Information and Prescription

Diagnosis: ☐ K51._ _ _ Other: ICD 10 Code: ______________________
Date of Diagnosis or Years with Disease: ______________________
Patients Allergies: ______________________ Latex allergy: ☐ NO ☐ YES
Patient Weight: ______________ kg or lbs Patient Height: ______________
Has the patient had a NEGATIVE tuberculin skin test? ☐YES ☐ NO ☐ NA
Has Hepatitis B been ruled out? ☐ YES ☐ NO
Prior Medications and length of treatment: ______________________
____
Expected First Dose Date: ________ Injection Instruction needed: ☐YES ☐NO ☐In-Office Training

☐ **Entyvio®** (vedolizumab) infuse Entyvio in NS 250ml over 30 minutes as directed
- ☐ Initial Dose: 300mg IV @ 0, 2, 6 weeks ☐ Maintenance Dose: 300mg IV every 8 weeks

☐ **Humira®** (adalimumab) ☐ 40mg Prefilled Syringe OR ☐ 40mg Pen Auto Injector ☐ Buffer free
- ☐ Starter Kit: 160 mg SC on day 1, 80 mg on day 15, then 40mg every other week
- ☐ Maintenance Dose: 40mg SC every other week

☐ **Remicade®** (infliximab) OR ☐**Inflectra®** OR ☐**Renflexis®** infuse in NS 250ml over 2 hours as directed
- Initial Dose: ☐ 5mg/kg @ 0, 2, 6 weeks
- Maintenance Dose: ☐ 5mg/kg every 8 weeks ☐10mg/kg every 8 weeks
- ☐ Other Remicade dosing: ______________________

☐ **Simponi®** (golimumab)
- ☐Initial Dose: Inject 200 mg SC at Week 0, followed by 100 mg at Week 2 then every 4 weeks
- ☐Maintenance Dose: Inject 100 mg SC every 4 weeks

☐ **Stelara®** (ustekinumab)
- ☐ Initial Single Dose IV x 1 hour: ☐<55g: 260mg ☐56-85kg: 390mg ☐>85kg: 520mg
- ☐ Maintenance Dose: 90mg subcutaneously every 8 weeks

☐ **Xeljanz®** (tofacitinib)
- ☐ Initial dose: 10 mg PO twice daily for at least 8 weeks
- ☐ Maintenance Dose: ☐ 5 mg PO twice daily ☐10 mg PO twice daily

☐ **Zeposia®** (ozanimod)
- ☐ Initial dose: 0.23 mg PO once daily days 1-4, then 0.46 mg once daily days 5-7
- ☐ Maintenance dose: 0.92 mg PO once daily beginning on day 8

Quantity Prescribed: ☐ QS 30 Days ☐ other: ______________
Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 11 ☐ Other: ______________

X ______________________
Physician Signature (no stamps) **Date**