elixir
SPECIALTY PHARMACY

Crohn's Disease 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.

Clinical Information and Prescription

Diagnosis: ☐ K50._ _ _ Crohn's Disease of the _____
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
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

Crohn's Disease Treatment Selection:

☐ **Cimzia®** (certolizumab) ☐ 2x200 mg Prefilled Syringe ☐ 2x200 mg Vial Kit
- ☐ Initial Dose: 400 mg SC @ 0, 2, 4 weeks, then as directed
- ☐ Maintenance Dose: ☐ 400 mg SC every 4 weeks ☐ 200 mg SC every 2 weeks

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

☐ **Humira®** (adalimumab) ☐ 40 mg Prefilled Syringe ☐ 40 mg Pen Auto Injector ☐ 20 mg Prefilled syringe ☐ Citrate/buffer free
- ☐ Starter Kit: 160 mg SC on day 1, 80 mg on day 15, then 40 mg every other week
- ☐ Maintenance Dose: 40 mg SC every other week ☐Other dosing:_____
- ☐ Pediatric Starter (<40 kg): 80 mg SC on day 1, 40 mg on day 15, then 20 mg every other week
- ☐ Pediatric Maintenance Dose (<40 kg): 20 mg SC every other week

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

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

Tysabri® (natalizumab) **is available only through the TOUCH™ program. Please Call 1-800-456-2255**

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

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