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: M or F 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: ☐ K51._ _ _ Ulcerative Colitis 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
Prior Medications and length of treatment: _____
_____
Expected First Dose Date: _____ Injection Instruction needed: ☐ YES ☐NO

☐ **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 OR ☐ 40 mg Pen Auto Injector ☐ 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

☐ **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: ☐ 5 mg/kg every 8 weeks ☐10 mg/kg every 8 weeks
- ☐ Other Remicade dosing: _____

☐ **Rinvoq®** (upadacitinib)
- ☐ Initial Dose: 45 mg PO once daily for 8 weeks
- Maintenance Dose: ☐ 15 mg PO once daily ☐ 30 mg PO once daily

☐ **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: ☐<55 g: 260 mg ☐56-85 kg: 390 mg ☐>85 kg: 520 mg
- ☐ Maintenance Dose: 90 mg 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 on days 1 through 4; then 0.46 mg PO once daily on days 5 to 7
- ☐ Maintenance Dose: 0.92 mg PO once daily starting on day 8

Quantity Prescribed:☐QS 30 days ☐Other: ____ **Refills Authorized**:☐ 0 ☐1 ☐2 ☐3 ☐ 6 ☐11 ☐Other: __

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