



Crohn's/Ulcerative Colitis Enrollment Form (A-I)

www.pyramidsparmacy.com

All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____
 ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (____) _____ - _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis (ICD-10):
 K50.00 Crohn's Disease of Small Intestine w/o Complications
 K50.10 Crohn's Disease of Large Intestine w/o Complications
 K50.80 Crohn's Disease of Small & Large Intestine w/o Complications
 K50.90 Crohn's Disease, Unspecified, w/o Complications
 K51.0 Ulcerative Pancolitis
 K51.8 Other Ulcerative Colitis
 K51.9 Ulcerative Colitis
 Other: _____

TB Test Completed: Yes No
 Date of Negative Test: _____
 If history of latent TB, has patient received treatment? Yes No
 Hep B Screening:
 Positive Negative N/A
 Date of Hep B Test: _____
 Does the patient have an active infection?
 Yes No

Allergies: NKDA Latex Other: _____
 Concomitant Medications: _____
 Please list previously tried and failed therapies & reason for discontinuing: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Cimzia® (Crohn's)	<input type="checkbox"/> Cimzia Starter Kit	<input type="checkbox"/> Initial Dose: Inject 400 mg subQ (two 200 mg syringes) at Weeks 0, 2 and 4, then maintenance dose.	1 Kit (6 prefilled syringes)	0
	<input type="checkbox"/> 200 mg/mL Prefilled Syringe <input type="checkbox"/> 200 mg/mL Vial	<input type="checkbox"/> Maintenance Dose: Inject 400 mg subQ every 4 weeks.		
<input type="checkbox"/> Entyvio® (Crohn's & UC)	<input type="checkbox"/> 300 mg Vial	<input type="checkbox"/> Infuse 300 mg IV over 30 minutes at Weeks 0, 2, and 6, then every 8 weeks thereafter.		
<input type="checkbox"/> Humira® (Crohn's & UC)	<input type="checkbox"/> Crohn's/UC Starter Kit <input type="checkbox"/> Crohn's/UC Starter Kit (Citrate-Free)	<input type="checkbox"/> Initial Dose: Inject 160 mg (two 80 mg pens) subQ on Day 1, then 80 mg on Day 15, then maintenance dose beginning Day 29. <input type="checkbox"/> Alternative Initial Dose: Inject 80 mg subQ on Day 1, 80 mg on Day 2, then 80 mg on Day 15, then maintenance dose beginning Day 29.	1 Kit (six 40 mg pens)	0
	<input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pen (Citrate-Free) <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.4 mL PFS (Citrate-Free)	<input type="checkbox"/> Maintenance Dose: Inject 40 mg subQ every OTHER week.		
<input type="checkbox"/> Inflectra® (Crohn's & UC)	<input type="checkbox"/> 100 mg Vial Patient Dosing Wt: _____ kg	<input type="checkbox"/> Initial Dose: Infuse _____mg (5mg/kg) IV at Weeks 0, 2, and 6, then maintenance dose. <input type="checkbox"/> Maintenance Dose: Infuse _____mg (5mg/kg) IV every 8 weeks. <input type="checkbox"/> Other: _____		

Deliver to: Patient Office Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution Permitted Dispense as Written

STAMP SIGNATURE NOT ALLOWED

Prescriber's Signature: _____ Date: _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.



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Allergies: NKDA Latex Other: _____
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4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Remicade® <small>(Crohn's & UC)</small>	<input type="checkbox"/> 100 mg Vial Patient Dosing Wt: _____kg	<input type="checkbox"/> Initial Dose: Infuse _____mg (5mg/kg) IV at Weeks 0, 2, and 6, then maintenance dose. <input type="checkbox"/> Maintenance Dose: Infuse _____mg (5mg/kg) IV every 8 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Renflexis™ <small>(Crohn's & UC)</small>	<input type="checkbox"/> 100 mg Vial Patient Dosing Wt: _____kg	<input type="checkbox"/> Initial Dose: Infuse _____mg (5mg/kg) IV at Weeks 0, 2, and 6, then maintenance dose. <input type="checkbox"/> Maintenance Dose: Infuse _____mg (5mg/kg) IV every 8 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Simponi® <small>(UC)</small>	<input type="checkbox"/> 100 mg/mL SmartJect® Autoinjector <input type="checkbox"/> 100 mg/mL Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject 200 mg subQ at Week 0, then 100 mg at Week 2, then maintenance dose. <input type="checkbox"/> Maintenance Dose: Inject 100 mg subQ every 4 weeks.		
<input type="checkbox"/> Stelara® <small>(Crohn's)</small>	<input type="checkbox"/> 130 mg/26 mL Vial <input type="checkbox"/> 90 mg/mL Prefilled Syringe	<input type="checkbox"/> Initial Dose: Infuse <input type="checkbox"/> 260 mg <input type="checkbox"/> 390 mg <input type="checkbox"/> 520 mg as IV induction dose, then begin maintenance dosing 8 weeks thereafter. <input type="checkbox"/> Maintenance Dose: Inject 90 mg subQ every 8 weeks.	_____ Vials	0
<input type="checkbox"/> Xeljanz® <small>(UC)</small>	<input type="checkbox"/> 5 mg Tablet <input type="checkbox"/> 10 mg Tablet	<input type="checkbox"/> Initial Dose: Take 10 mg by mouth twice daily for 8 weeks. <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Take 5 mg by mouth twice daily. <input type="checkbox"/> Take 10 mg by mouth twice daily.		
<input type="checkbox"/> OTHER:	<input type="checkbox"/> Drug Strength:	<input type="checkbox"/> Directions:		

Deliver to: Patient Office Other: _____ Date: _____ Needs by Date: _____

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