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

PYRAMIDS SPECIALTY PHARMACY

www.pyramidspharmacy.com

All our referral forms are available on our website.

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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
❑ Cimzia® *(Crohn's)*	❑ Cimzia Starter Kit	❑ **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
	❑ 200 mg/mL Prefilled Syringe ❑ 200 mg/mL Vial	❑ **Maintenance Dose**: Inject 400 mg subQ every 4 weeks.		
❑ Entyvio® *(Crohn's & UC)*	❑ 300 mg Vial	❑ Infuse 300 mg IV over 30 minutes at Weeks 0, 2, and 6, then every 8 weeks thereafter.		
❑ Humira® *(Crohn's & UC)*	❑ Crohn's/UC Starter Kit ❑ Crohn's/UC Starter Kit (Citrate-Free)	❑ **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. ❑ ***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 (3 X 80 mg pens)	0
	❑ 40 mg/0.8 mL Pen ❑ 40 mg/0.4 mL Pen (Citrate-Free) ❑ 40 mg/0.8 mL PFS ❑ 40 mg/0.4 mL PFS (Citrate-Free) ❑ 80 mg Pen (Citrate-Free)	❑ **Maintenance Dose**: Inject 40 mg subQ every *OTHER* week. #Pens: _____ #Refills: _____		
❑ Other Humira®				
❑ Inflectra® *(Crohn's & UC)*	❑ 100 mg Vial *Patient Dosing Wt:* _____ *kg*	❑ **Initial Dose**: Infuse _____ mg (5mg/kg) IV at Weeks 0, 2, and 6, then maintenance dose. ❑ **Maintenance Dose**: Infuse _____ mg (5mg/kg) IV every 8 weeks. ❑ **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.