Crohn's/Ulcerative Colitis Enrollment Form (J-Z)

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
❑ Remicade® *(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**: ______________		
❑ Renflexis™ *(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**: ______________		
❑ Simponi® *(UC)*	❑ 100 mg/mL SmartJect® Autoinjector ❑ 100 mg/mL Prefilled Syringe	❑ **Initial Dose**: Inject 200 mg subQ at Week 0, then 100 mg at Week 2, then maintenance dose. ❑ **Maintenance Dose**: Inject 100 mg subQ every 4 weeks.		
❑ Stelara® *(Crohn's)*	❑ 130 mg/26 mL Vial	❑ **Initial Dose**: Infuse ❑ 260 mg ❑ 390 mg ❑ 520 mg as IV induction dose, then begin maintenance dosing 8 weeks thereafter.	_____ Vials	0
	❑ 90 mg/mL Prefilled Syringe	❑ **Maintenance Dose**: Inject 90 mg subQ every 8 weeks.		
❑ Xeljanz® *(UC)*	❑ 5 mg Tablet ❑ 10 mg Tablet	❑ **Initial Dose**: Take 10 mg by mouth twice daily for 8 weeks. ❑ **Maintenance Dose**: ❑ Take 5 mg by mouth twice daily. ❑ Take 10 mg by mouth twice daily.		
❑ **OTHER**: ________	❑ **Drug Strength**: ________	❑ **Directions**: ______________		

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.