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: __________ Gender: ______ SS#__________
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: ____________________
Contact Person: ____________________
Contact's Phone: ____________________
Address: ____________________
City: ____________ State: ______ Zip: ______
Office Phone#: ____________________
Office Fax#: ____________________
DEA# __________ NPI# __________
License#: __________ Medicaid UPIN#: __________
Physician Specialty: ____________________
Date Shipment Needed: ____________________
Ship to: ☐**Patient** ☐**Prescriber** ☐**Other** __________
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

Diagnosis: ☐ K50._ _ _ Other: ____________________ ICD 10 Code: __________
Patients Allergies: ____________________
Date of Diagnosis or Years with Disease: __________ Latex allergy: ☐ NO ☐ YES Patient Weight: __________ ☐ kg or ☐ lbs
Patient Height: __________ ☐ in ☐ cm Hepatitis Status: ____________________
Has the patient had a NEGATIVE tuberculin skin test? ☐ YES ☐ No Date: ____/_____/__________
Prior Medications and length of treatment: ____________________
Is patient on samples? ☐ Yes ☐ No Expected First Dose Date: __________ Injection Instruction needed: ☐ Yes ☐ No
Specialty Pharmacy to coordinate home health infusion nurse visit as necessary? ☐ Yes ☐ No

****If ancillary supplies needed (i.e. Diluents, Flushes, EpiPen, etc) please send additional prescriptions as needed.****

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Patient Name: ______________________ **Patient Date of Birth:** ______________

Prescriber Name: ______________________ **Office Phone:** ______________ **Date:** ________

Prescriber Address: ____

☐ **Cimzia®** (certolizumab) ☐ 2x200mg Prefilled Syringe ☐ 2x200mg Vial Kit
- ☐ Initial Dose: 400mg SC at 0, 2, 4 weeks, then as directed
- ☐ Maintenance Dose: ☐ 400mg SC every 4 weeks ☐ 200mg SC every 2 weeks

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

☐ **Humira®** (adalimumab) ☐ 20mg/0.2mL CF PFS ☐ 40mg/0.4mL CF Pen ☐ 40mg/0.4mL CF PFS
☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL PFS ☐ Other: ______________
- ☐ Starter Kit: 160mg SC on day 1, 80mg on day 15, then 40mg every other week
- ☐ Pediatric Starter (<40kg): 80mg SC on day 1, 40mg on day 15, then 20mg every other week
- ☐ Starter Dose Other: ______________________
- ☐ Maintenance Dose: 40mg SC every other week
- ☐ Maintenance Dose: 20mg SC every other week
- ☐ Maintenance Dose Other: ______________________

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

☐ **Rinvoq®** (upadacitinib)
- Initial Dose: ☐ 45mg PO once daily for 12 weeks
- Maintenance Dose: ☐ 15mg PO once daily ☐ 30mg PO once daily

☐ **Skyrizi®** (risankizumab) Infuse diluted Skyrizi in 5% Dextrose over 1 hour as directed
- ☐ Initial Dose: 600mg IV at 0, 4, 8 weeks ☐ Maintenance Dose: 360mg SC at week 12 then every 8 weeks

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

☐ **Tysabri®** (natalizumab) To order Tysabri please contact the TOUCH Prescribing Program at 1-800-456-2255 and Indicate Elixir Specialty Pharmacy as your preferred pharmacy provider
Mix Tysabri 300mg/15mL in NS 100mL & infuse IV over 1 hour
- ☐ Infuse 300mg via IV infusion once every 4 weeks
- ☐ Other: ______________________

Dispense Quantity: ______________ Refills: ______________

Prescriber Signature: *X* ______________________________

If Brand required "Dispense as Written" must be handwritten.

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