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: _____ 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: ☐ K51._ _ _ 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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Prescriber Name: _____ **Office Phone:** _____ **Date:** _____

Prescriber Address: _____

Medication	Strength	Dose and Directions	Quantity/Refills
☐ **Entyvio®** (vedolizumab)	☐ 300mg Vial ☐ 108mg/0.68mL Pen ☐ 108mg/0.68mL PFS	☐ Initial Dose: 300mg IV @ weeks 0, 2, and 6 ☐ Initial Dose: 300mg IV @ week 0 and 2 ☐ Maintenance Dose: 108mg SC at week 6, then every 2 weeks thereafter ☐ Maintenance Dose: 300mg IV every 8 weeks	Quantity:_____ Refills: _____
☐ **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 ☐ 80mg/0.8mL CF Pen	☐ Starter Kit: 160 mg SC on day 1, 80 mg on day 15, then 40mg every other week ☐ Pediatric Starter Kit (>40kg): 160mg SC on day 1, 80mg on days 8 and 15, then continue as instructed. ☐ Pediatric Starter Kit (<40kg): 80mg SC on day 1, 40mg on days 8 and 15, then continue as instructed ☐ Starter Kit: Other: _____ ☐ Maintenance Dose: 40mg SC every other week ☐ Maintenance Dose: 40mg SC every week ☐ Maintenance Dose: 80mg SC every other week ☐ Maintenance Dose: 20mg SC every week ☐ Maintenance Dose: Other: _____	Quantity:_____ Refills: _____
☐ **Remicade®** (infliximab) ☐**Avsola®** ☐**Inflectra®** ☐ **Infliximab®** ☐**Renflexis®**	☐ 100mg/mL Vial	Initial Dose: ☐ 5mg/kg @ 0, 2, 6 weeks Maintenance Dose: ☐ 5mg/kg every 8 weeks ☐10mg/kg every 8 weeks ☐ Other dosing: _____	Quantity:_____ Refills: _____
☐ **Rinvoq®** (upadacitinib)	Initial: ☐ 45mg Maintenance: ☐ 30mg ☐ 15mg	☐ Initial Dose: 45mg PO once daily for 8 weeks ☐ Maintenance Dose: 1 tablet by mouth once daily ☐ Other: _____	Quantity:_____ Refills: _____
☐ **Other:**_____	☐ **Strength:**_____	☐ **Dose:** _____	Quantity:_____ Refills: _____

Prescriber Signature: *X*_____

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

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☐ **New to Therapy**
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Patient Name: _____ **Patient Date of Birth:** _____

Prescriber Name: _____ **Office Phone:** _____ **Date:** _____

Prescriber Address: _____

Medication	Strength	Dose and Directions	Quantity/Refills
☒ **Simponi®** (golimumab)	☐ 100mg/mL PFS ☐ 100mg/mL Prefilled SmartJect Pen	☐ Initial Dose: Inject 200mg SC at Week 0, followed by 100mg at Week 2, then every 4 weeks ☐ Maintenance Dose: Inject 100mg SC every 4 weeks ☐ Other: _____	Quantity:_____ Refills: _____
☐ **Stelara®** (ustekinumab)	Initial: ☐ 130mg/26mL Vial Maintenance: ☐ 90mg/mL PFS	☐ Initial Single Dose IV x 1 hour: ☐<55g: 260mg ☐56-85kg: 390mg ☐>85kg: 520mg ☐ Maintenance Dose: 90mg subcutaneously every 8 weeks ☐ Other: _____	Quantity:_____ Refills: _____
☐ **Xeljanz®** (tofacitinib)	Initial: ☐ 10mg Maintenance: ☐ 10mg ☐ 5mg	☐ Initial dose: 10mg PO twice daily for at least 8 weeks ☐ Maintenance: Take 1 tablet by mouth twice daily ☐ Other: _____	Quantity:_____ Refills: _____
☐ **Xeljanz XR®** (tofacitinib)	Initial: ☐ 22mg Maintenance: ☐ 22mg ☐ 11mg	☐ Initial dose: 22mg PO once daily for at least 8 weeks ☐ Maintenance: Take 1 tablet by mouth once daily ☐ Other: _____	Quantity:_____ Refills: _____
☐ **Other:**_____	☐ **Strength:**_____	☐ **Dose:** _____	Quantity:_____ Refills: _____

Prescriber Signature: *X*_____

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

Updated September 2023