elixir
SPECIALTY PHARMACY

# Crohn's Disease Enrollment Form

Phone: (877) 437-9012 Fax: (877) 309-0687

☐ New to Therapy
☐ Current Therapy

## Customer Information

Customer Name: _____
Date of Birth: _____ Sex: _____ Caregiver: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Please attach copy of front and back of customers prescription insurance card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Customer: _____
ID# _____ Group# _____
RxBIN: _____ RxPCN: _____

## Prescriber Information

Practice/Organization Name: _____
Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____
DEA# _____ NPI# _____
License#: _____ Medicaid UPIN#: _____
Physician Specialty: _____
Date Shipment Needed: _____
Ship to: ☐Patient ☐Prescriber ☐Infusion Clinic
Shipment Address: _____ Attn: _____
City: _____ State: _____ Zip: _____
*If shipped to the physician's office, physician accepts on behalf of patient for administration in office.*



20-4737

## Clinical Information and Prescription

Diagnosis: ☐ K50._ _ _ Crohn's Disease of the _____
Other: _____ ICD 10 Code: _____
Date of Diagnosis or Years with Disease: _____
Patients Allergies: _____
Latex allergy: ☐ NO ☐ YES
Patient Weight: _____ kg or lbs Patient Height: _____
Has the patient had a NEGATIVE tuberculin skin test? ☐ YES ☐ NO
Has Hepatitis B been ruled out? ☐ YES ☐ NO
Prior Medications and length of treatment: _____
_____
Expected First Dose Date: _____
Injection Instruction needed: ☐ YES ☐ NO ☐ In-Office Training

### Crohn's Disease Treatment Selection:

☐ Cimzia® (certolizumab) ☐ 2x200mg Prefilled Syringe ☐ 2x200mg Vial Kit
- ☐ Initial Dose: 400mg SC @ 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 @ 0, 2, 6 weeks ☐ Maintenance Dose: 300mg IV every 8 weeks

☐ Humira® (adalimumab) ☐ 40mg Prefilled Syringe ☐ 40mg Pen Auto Injector ☐ 20mg Prefilled syringe ☐ Citrate/buffer free
- ☐ Starter Kit: 160 mg SC on day 1, 80 mg on day 15, then 40mg every other week
- ☐ Maintenance Dose: 40mg SC every other week ☐Other dosing: _____
- ☐ Pediatric Starter (<40 kg): 80 mg SC on day 1, 40 mg on day 15, then 20 mg every other week
- ☐ Pediatric Maintenance Dose (<40 kg): 20 mg SC every other week

☐ Remicade® (infliximab) OR ☐Inflectra® OR ☐Renflexis® Infuse in NS 250ml over 2 hours as directed
- Initial Dose: ☐ 5mg/kg @ 0, 2, 6 weeks
- Maintenance Dose: ☐ 5mg/kg every 8 weeks ☐10mg/kg every 8 weeks
- ☐ Other Remicade dosing: _____

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

Tysabri® (natalizumab) is available only through the TOUCH™ program. Please Call 1-800-456-2255

Quantity Prescribed: ☐ QS 30 Days ☐ other: _____
Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: _____

X _____
Physician Signature (no stamps) Date