# Crohn's Disease & Ulcerative Colitis Enrollment Form

Phone: 800-361-1260
Fax: 800-737-4920

CORNERSTONE PHARMACY
*an affiliate of Medical Centre Pharm*

| PATIENT INFORMATION (PLEASE PRINT) | | | | |
|---|---|---|---|---|
| Patient Name (Last, First, Mi) | | | ☐ Male ☐ Female | |
| Date of Birth (mm/dd/yyyy) | SS# | Phone (Daytime) | Phone (Evening) | |
| Street Address (Please include Suite/Apt Number) | | City | State | Zip |

| INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT'S PHARMACY BENEFIT CARD - FRONT AND BACK) | | |
|---|---|---|
| Primary Insurance | | Policy Holder |
| Policy # | Group # | Phone |

| DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis) | | | |
|---|---|---|---|
| ☐ K50.00 Crohn's Disease | ☐ K50.10 Crohn's Disease | ☐ K50.80 Crohn's Disease | ☐ K50.90 Crohn's Disease |
| ☐ K50.80 Ulcerative Colitis | ☐ K51.20 Ulcer. Chron Proc | ☐ K51.90 Ulcerative Colitis | ☐ _____, Other |
| ☐ Other ICD9 _____ | | Is patient new to therapy? ☐ yes ☐ no | Date of Diagnosis: _____/_____/_____ |
| Patient tested for TB: ☐ yes ☐ no | If yes, Date ____/____/_____ | Result: ☐ Positive ☐ Negative | |
| Patient Weight: _____ | | Drug Allergies: _____ **OR** ☐ NKDA | |

| PREVIOUS MEDICATIONS (Please specify dosage and time on therapy) | | |
|---|---|---|
| *Medication Strength and Dose* | *Date of Therapy* | *Reason for Discontinuing* |
| | | |

| PRESCRIPTION INFORMATION | | | |
|---|---|---|---|
| *Rx-Medication* | *Dose and Frequency* | *Quantity* | *Refills* |
| Humira® (adalimumab) | | | |
| ☐ Humira® Crohn's Disease Start Pk<br>6 - Self-Injectable Pens<br>40 mg/0.8 ml | ☐ Four (#4) 40 mg (0.8ml) subcutaneously injections day 1 (160mg)<br>and<br>Two (#2) 40 mg 0.8ml) subcutaneously injections day 15 (80mg)<br>☐ Other: _____ | ☐ 28 day supply | None |
| ☐ Humira® Self-Injectable Pen<br>40 mg/0.8 ml<br>☐ Humira® Pre-Filled syringe<br>40 mg/0.8 ml | ☐ 40 mg (0.8ml) subcutaneously injection once every other week<br>☐ Other: _____ | ☐ 28 day supply<br>☐ 84 day supply<br>☐ Other: _____ | ☐ 1 year<br>☐ Other:<br>_____ |
| Cimzia® (certolizumab pegol) | | | |
| ☐ Cimzia® Starter Kit<br>6 - 200mg prefilled syringes | ☐ Two (#2) 200 mg prefilled syringes SC day 1 (400mg); and,<br>Two (#2) 200 mg prefilled syringes SC (400mg) at end of week 2<br>and Two (#2) 200 mg prefilled syringes SC (400mg) at end of week 4<br>☐ Other: _____ | ☐ 28 day supply | None |
| ☐ Cimzia® Maintenance Dose<br>2 – 200 mg prefilled syringes<br>☐ Cimzia® Maintenance Dose<br>2 – 200 mg vials | ☐ Two (#2) 200 mg prefilled syringes SC (400mg) every 4 weeks<br>☐ Other: _____ | ☐ 28 day supply<br>☐ 84 day supply<br>☐ Other: _____ | ☐ 1 year<br>☐ Other:<br>_____ |
| ☐ Remicade® (infliximab)<br>100 mg / 20 ml vial | Not for Self Administration | # _____ | |

| DELIVERY AND PATIENT EDUCATION INSTRUCTIONS | | | |
|---|---|---|---|
| ☐ Patient's Home | ☐ Physician's Office | Date Needed | Patient needs Education Kit? ☐ yes ☐ no |
| Teaching to be done at: | ☐ Patient's Home | ☐ Physician's Office | ☐ Not needed |

| PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION | | | | |
|---|---|---|---|---|
| Physician Name | | License # | DEA # | UPIN # |
| Office Contact | Phone | Fax | NPI# | |
| Street Address (Please include Suite Number) | | City/State/Zip | | |
| Physician's Signature (required) | | Date (required) | | |
| This prescription will be filled generically unless Prescriber writes "DAW" in the box to the right. | | | | |