



Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

Crohn's/Ulcerative Colitis Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis — Please include diagnosis name with ICD-10 code	Additional Information	Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
<input type="checkbox"/> K50.00 Crohn's disease of small intestine without complications <input type="checkbox"/> K50.10 Crohn's disease of large intestine without complications <input type="checkbox"/> K50.90 Crohn's disease, unspecified, without complications <input type="checkbox"/> Other Diagnosis: ICD-10 Code _____ Description _____ Date of diagnosis _____ Has a TB test been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date _____ Review Date _____	Weight _____ kg/lbs Height _____ cm/in Allergies _____ Lab Data _____ Prior Therapies _____ Concomitant Medications _____ Additional Comments _____ Injection Training Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200 mg/mL Vial Kit <input type="checkbox"/> 200 mg/mL Starter Kit <input type="checkbox"/> 200 mg/mL Prefilled Syringe	<input type="checkbox"/> Initiation - Inject 400 mg SQ at Weeks 0, 2, and 4 <input type="checkbox"/> Maintenance - Inject 400 mg SQ every 4 weeks		
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300 mg Vial	<input type="checkbox"/> Initiation - Infuse 300 mg IV over 30 minutes at Weeks 0, 2, and 6 <input type="checkbox"/> Maintenance - Infuse 300 mg IV over 30 minutes every 8 weeks		
<input type="checkbox"/> Humira®	Starter Kits: <input type="checkbox"/> 80 mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) <input type="checkbox"/> 40mg/0.8mL Crohns Disease Starter Package Prefilled Syringe <input type="checkbox"/> 40mg/0.8mL Crohns Disease Starter Package Pre-Filled Pen Maintenance: <input type="checkbox"/> 40mg/0.4mL Pre-Filled Pen (Citrate Free) <input type="checkbox"/> 40mg/0.4mL Pre-Filled Syringe (Citrate Free) <input type="checkbox"/> 40mg/0.8mL Pre-Filled Pen Kit <input type="checkbox"/> 40mg/0.8mL Pre-Filled Syringe Kit Other: _____	Adult: <input type="checkbox"/> Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance: Inject 40 mg SQ every other week (starting Day 29) Pediatric (≥ 6 years and adolescents) 17 kg to <40 kg <input type="checkbox"/> Initiation: Inject 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance: Inject 20 mg SQ every other week (starting Day 29) ≥40 kg <input type="checkbox"/> Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance: Inject 40 mg SQ every other week (starting Day 29)		
<input type="checkbox"/> Inflectra®	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 <input type="checkbox"/> Maintenance - Infuse 5 mg/kg every 8 weeks		
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 <input type="checkbox"/> Maintenance - Infuse 5 mg/kg every 8 weeks		
<input type="checkbox"/> Renflexis®	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 <input type="checkbox"/> Maintenance - Infuse 5 mg/kg every 8 weeks		
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg/mL SmartJect Autoinjector <input type="checkbox"/> 100 mg/mL Prefilled Syringe	<input type="checkbox"/> Initiation - Inject 200 mg SQ at Week 0 then 100 mg at Week 2 <input type="checkbox"/> Maintenance - Inject 100 mg SQ every 4 weeks		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 130 mg/26 mL solution single dose vial <input type="checkbox"/> 90 mg/mL Prefilled Syringe Date of Initial Infusion: _____	<input type="checkbox"/> Initiation - Infuse: <input type="checkbox"/> 260 mg <input type="checkbox"/> 390 mg <input type="checkbox"/> 520 mg as initial IV dose as directed by prescriber <input type="checkbox"/> Maintenance - Inject 90 mg SQ every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet <input type="checkbox"/> 11mg XR tablet <input type="checkbox"/> 22mg XR tablet	<input type="checkbox"/> Initiation: <input type="checkbox"/> 10 mg twice daily for 8 weeks <input type="checkbox"/> XR: 22 mg once daily for 8 weeks <input type="checkbox"/> Maintenance: <input type="checkbox"/> 5 mg twice daily <input type="checkbox"/> XR: 11 mg once daily <input type="checkbox"/> 10 mg twice daily <input type="checkbox"/> XR: 22 mg once daily		

***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.

Ship to: Patient Office Other _____ Date _____ Needs by Date _____

Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____ Supervising Physician Signature: _____ Date _____

Electronic or digital signatures not accepted.

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.