



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.

This form is not a valid prescription in Arizona

## 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 \_\_\_\_\_  
 (Must fax a copy of patient's insurance card including both sides)

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

**Diagnosis** — Please include diagnosis name with ICD-10 code  
 K50.00 Crohn's disease of small intestine without complications  
 K50.10 Crohn's disease of large intestine without complications  
 K50.90 Crohn's disease, unspecified, without complications  
 Other Diagnosis: ICD-10 Code \_\_\_\_\_ Description \_\_\_\_\_  
 Has a TB test been performed?  Yes  No  
 Does the patient have an active infection?  Yes  No  
**Start Date** \_\_\_\_\_ **Review Date** \_\_\_\_\_

**Additional Information** Therapy:  New  Reauthorization  Restart  
 Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in  
 Allergies \_\_\_\_\_  
 Lab Data \_\_\_\_\_  
 Prior Therapies \_\_\_\_\_  
**Injection Training Required:**  Yes  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"/> Humira®	Starter Kits: <input type="checkbox"/> 80 mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) <input type="checkbox"/> 40 mg/0.8mL Crohns Disease Starter Package Prefilled Syringe <input type="checkbox"/> 40 mg/0.8mL Crohns Disease Starter Package Pre-Filled Pen Maintenance: <input type="checkbox"/> 40 mg/0.4mL Pre-Filled Pen (Citrate Free) <input type="checkbox"/> 40 mg/0.4mL Pre-Filled Syringe (Citrate Free) <input type="checkbox"/> 40 mg/0.8mL Pre-Filled Pen Kit <input type="checkbox"/> 40 mg/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) <b>17 kg to &lt;40 kg</b> <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) <b>≥40 kg</b> <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"/> Rinvoq	<input type="checkbox"/> 45 mg tablet-Loading Dose <input type="checkbox"/> 15 mg tablet-Maintenance Dose <input type="checkbox"/> 30 mg tablet-Maintenance Dose	<input type="checkbox"/> Initiation: Take 45 mg PO once daily for 8 weeks <input type="checkbox"/> Maintenance Dose: Take 15 mg PO once daily <input type="checkbox"/> Alternative Maintenance Dose: Take 30 mg PO once daily		
<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"/> Skyrizi	<input type="checkbox"/> 600 mg/10 mL single-dose vial-initiation Dose <input type="checkbox"/> 360 mg/2.4 mL single-dose prefilled cartridge with On-Body injector-Maintenance Dose Date of Initial Infusion: _____	<input type="checkbox"/> Initiation-Infuse 600 mg as initial IV dose at Week 0, Week 4, and Week 8 as directed by prescriber <input type="checkbox"/> Maintenance Dose-360 mg by SQ injection at week 12, and every 8 weeks thereafter		
<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"/> 5 mg tablet <input type="checkbox"/> 10 mg tablet <input type="checkbox"/> 11 mg XR tablet <input type="checkbox"/> 22 mg 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		
<input type="checkbox"/> Zeposia	<input type="checkbox"/> 0.92 mg capsule <input type="checkbox"/> 7-Day Starter Pack <input type="checkbox"/> 37 Day Starter Kit (Starter Pack + 0.92 mg capsules)	<input type="checkbox"/> Initiation: Take 0.23 mg once daily for days 1-4, then take 0.46 mg once daily for days 5-7, then take 0.92 mg once daily on day 8 and every day thereafter <input type="checkbox"/> Maintenance: Take 0.92 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-first fill only  Office-all fills  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. This form is not a valid prescription in Arizona.



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**Additional Information** Therapy:  New  Reauthorization  Restart  
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 Allergies \_\_\_\_\_  
 Lab Data \_\_\_\_\_  
 Prior Therapies \_\_\_\_\_  
**Injection Training Required:**  Yes  No

## PRESCRIPTION INFORMATION (cont.)

Medication	Dose / Strength	Directions	Qty	Refills
<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"/> 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"/> Avsola®	<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		

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Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

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