INFLAMATORY BOWEL DISEASE ENROLLMENT FORM

Fax Referral To: 252-726-0792 Phone: 844-418-9857

PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ○ M ○ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax ID: _____
Office Contact: _____ Phone: _____

DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____

Diagnosis: K50.90 Crohn's Disease K51.90 Ulcerative Colitis Other: _____ DX Code: _____

Patient Weight: _____ Patient Allergies: _____

Hepatitis Test Result: _____ TB/PPD Test Given? ☐ Yes ☐ No Test Date: _____ Test Results: _____

Prior Failed Meds:

Corticosteroids	Duration _____	Purinethol / 6-MP	Duration _____	Sulfasalazine	Duration _____
Azathioprine	Duration _____	5-ASA (Mesalamine) Oral	Duration _____	Remicaid	Duration _____
Methotrexate	Duration _____	5-ASA (Mesalamine) Rectal	Duration _____	Other _____	Duration _____

Current Meds: _____

Meds to be stopped before starting new medication (list time to start new med) _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **CIMZIA®**	☐ Prefilled Syringes Starter Kit	☐ **Induction Dose**: Inject 400mg SC on day 1, 14, and 28	6	0
	☐ 200mg/ml Prefilled Syringe ☐ 200mg Lyophilized Powder	☐ **Maintenance**: Inject 400mg SC every 4 weeks ☐ _____	2	
☐ **HUMIRA®**	☐ Crohn's Disease / Ulcerative Colitis Starter Kit	☐ **Induction Dose**: Inject 160mg SC on day 1, then 80mg SC on day 15, then switch to maintenance dose	6	0
	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ **Maintenance**: Inject 40mg SC other week ☐ _____	2	
☐ **SIMPONI®**	☐ 100mg/ml Smartject® Autoinjector	☐ **Induction Dose**: Inject 200mg SC at week 0, 100mg SC at week 2 and then switch to maintenance dose	3	0
	☐ 100mg/ml Prefilled Syringe	☐ **Maintenance**: Inject 100mg SC every 4 weeks	1	
☐ **UCERIS®**	☐ 9mg Tablets	☐ Take one tablet daily in the morning with or without food	30	1
☐ **XIFAXAN®**	☐ 550mg Tablets	☐ Take one tablet three times daily for 14 days	42	
☐ **OTHER**				

PRODUCT DELIVERY: ○ Patient's Home ○ Physician's Office ○ Pharmacy to Coordinate

INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

By signing this form, you are authorizing Medical Park Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____ _____ _____ _____
PRODUCT SUBMISSION PERMITTED DATE DISPENSE AS WRITTEN DATE