Pharmaceutical Specialties, Inc.
Family owned, patient focused.

**Phone: 800-818-6486 ◆ Fax: 800-818-6490 ◆ www.psipharmacy.com**

# Prescription & Enrollment Form - Crohn's Disease/Ulcerative Colitis

## Patient Information

***Demographics do not need to be completed if a demographic sheet is to follow***

Patient:_____ Weight:_____ DOB:_____ Last 4 digits of SSN:_____
Address:_____ City:_____ State:_____ Zip:_____
Cell #:_____ Home #:_____ Gender: ☐ M ☐ F ***Ship initial dose to:*** ☐ **Patient** ☐ **Office**

## Insurance Information

***To expedite the benefits investigation, please attach:***
☐ ***Enlarged copy of the front and back of the insurance card*** ☐ ***Chart notes*** ☐ ***Labs*** ☐ ***Supporting clinical documentation***
***Insurance:***_____ ***Pharmacy Help Desk Phone:***_____
***ID Number:***_____ ***Group Number:***_____
***Rx Group:***_____ ***Rx BIN:***_____ ***Rx PCN:***_____

## Patient Assessment

**Diagnosis**
☐ 555.9 Crohn's Disease NOS ☐ 555.0 Small Intestine ☐ Other ICD 9 _____
☐ 555.1 Large Intestine ☐ 556.9 Ulcerative Colitis ☐ Other ICD 9 _____

- Crohn's Severity? ☐ Moderate ☐ Severe
- Fistulizing Crohn's? ☐ Moderate ☐ Severe
- Is patient new to therapy? ☐ Yes ☐ No
- Has TB test been performed? ☐ Yes ☐ No
  If Yes, results:_____ Date of test:_____
- Allergies: _____
- Diagnosed with CHF? ☐ Yes ☐ No
- Diagnosed with Lymphoma? ☐ Yes ☐ No
- Does patient have serious/active infection? ☐ Yes ☐ No
- Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
  If Yes, has Hepatitis B been ruled out? ☐ Yes ☐ No

## Prior (Failed) Medications

| Medication | Strength | Start Date | End Date | Medication | Strength | Start Date | End Date |
|---|---|---|---|---|---|---|---|
| Other biologics: _____ | | | | Methotrexate | | | |
| Azathioprine/6-MP | | | | Sulfasalazine/5-ASA | | | |
| Corticosteroids | | | | Other: _____ | | | |

## Prescription Information

### HUMIRA®

☐ Crohn's Starter Package
Induction Dose: Inject subcutaneously 160 mg (4 Pens) on day 1, then 80 mg (2 pens) on day 15, then maintenance dosing.

☐ 40 mg Pen ☐ 40 mg Prefilled Syringe
Maintenance Dose: Inject subcutaneously 40 mg (1 injection) every other week. **Quantity:**_____ **Refills:**_____

☐ Training required by myHUMIRA ***(Physician and patient signature required for injection training)***

### Cimzia®

☐ Cimzia® Starter Kit
Induction Dose: Inject subcutaneously 400 mg (2 vials) on day 1, and at weeks 2 and 4.

☐ 200 mg/1 mL Prefilled Syringe ☐ 200 mg Vial
Maintenance Dose: Inject subcutaneously 400 mg (2 vials) every 4 weeks. **Quantity:**_____ **Refills:**_____

☐ Training required by CIMplicity® ***(Physician and patient signature required for injection training)***

### Simponi®

☐ Induction Dose: Inject subcutaneously 200 mg (2 injections) at week 0, followed by 100 mg at week 2, then maintenance dosing.
☐ Maintenance Dose: Inject subcutaneously 100 mg (1 injection) every 4 weeks. **Quantity:**_____ **Refills:**_____
☐ 100 mg/1 mL SmartJect® autoinjector ☐ 100 mg/1 mL single dose prefilled syringe

## Patient Support Program

I authorize Pharmaceutical Specialties, Inc to enroll me in the pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis and provide educational information regarding therapies. I understand I may revoke this authorization at anytime in writing by sending a letter to PSI, 150 Cleveland Rd, Bogart, GA 30622. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original.

**Patient Signature (required for participation):**_____ **Date:**_____ ☐ **myHUMIRA®** ☐ **CIMplicity®**

Provider Name: _____ NPI:_____ DEA:_____ License #:_____
Practice Name:_____
Address: _____ City: _____ State: _____ Zip:_____
Office Contact: _____ Phone: _____ Fax: _____

❑ *Physician's office to train*

❑ *Uninsured patient, needs assistance*

**Product Substitution Permitted** **Date**

**Dispense As Written** **Date**

PSI112014