

Crohn's and Ulcerative Colitis Enrollment Form

Century Specialty Script
Fax Referral To: 877-521-5353
Phone: 800-521-3949



Date: _____

Need by date: _____ Ship to: Patient's home Prescriber 1st Order Only Prescriber All Orders

Patient Information

Please complete the following or send patient demographic sheet

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 DOB: _____ Gender: M F

Prescriber Information

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 DEA: _____ NPI#: _____
 Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
 Secondary Insurance: _____ ID#: _____ Group: _____
 Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Medical Information (Section must be completed to process prescription)

(Attach separate sheet if needed)

Prior Authorization Insurance Number: _____

Diagnosis - Please include diagnosis name with ICD-10 code

- K50.00 Crohn's disease of small intestines without complications
- K50.8 Crohn's disease of both intestines without complications
- K50.10 Crohn's disease of large intestines without complications
- K50.00 Crohn's disease, unspecified, without complications
- K20.0 Eosinophilic Esophagitis
- Other diagnosis: ICD-10 code _____

Description _____ Date of Description _____

Has a TB test been performed? Yes No

Does the Patient have an active infection? Yes No

Start Date _____ Review Date _____

Therapy Details: New Reauthorization Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required? Yes No

PA# _____

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/mL Vial Kit <input type="checkbox"/> 200 mg/mL Starter Kit <input type="checkbox"/> 200mg/mL prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 400mg SC at Weeks 0, 2, and 4 <input type="checkbox"/> Maintenance Dose: Inject 200mg SC every 2 weeks		
<input type="checkbox"/> Dupixent	<input type="checkbox"/> PFS with needle shield 300 mg/2 mL <input type="checkbox"/> Prefilled Pen 300 mg/2 mL	<input type="checkbox"/> Inject 300 mg Sub Q every week		
<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> Loading Dose: Inject 300mg IV over 30 minutes at Weeks 0, 2, and 6. <input type="checkbox"/> Maintenance Dose: Infuse 300mg IV over 30 minutes every 8 weeks		
<input type="checkbox"/> Humira	Starter Kits: <input type="checkbox"/> 80mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) 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"/> Other: _____	Adult: <input type="checkbox"/> Loading Dose: Inject 160mg SC on Day 1, then 80mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week (starting Day 29) Pediatric (>6 years and adolescents) 17kg to < 40kg <input type="checkbox"/> Loading Dose: Inject 80mg SC on Day 1, 40mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 20mg SC every other week (starting Day 29) Pediatric (>6 years and adolescents) > 40kg <input type="checkbox"/> Loading Dose: Inject 160mg SC on Day 1, 80mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week (starting Day 29)		

Prescriber Signature: _____ DAW (Dispense as Written) Y N Date: _____

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Therapy Details: New Reauthorization Restart

Weight _____ kg/lbs Height _____ cm/in
 Allergies _____
 Lab Data _____
 Prior Therapies _____
 Concomitant Medications _____
 Additional Comments _____
 Injection Training Required? Yes No
 PA# _____

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Loading Dose: Infuse 5mg/kg at Weeks 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: Infuse 5mg/kg every 8 weeks		
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> Induction Therapy – 45 mg tablet <input type="checkbox"/> Maintenance Therapy – 15 mg or 30 mg tablets	<input type="checkbox"/> Induction Therapy: 45 mg PO daily x 8 weeks. Maintenance Therapy: <input type="checkbox"/> 15 mg PO daily <input type="checkbox"/> 30 mg PO daily		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100mg/mL SmartJect Auto Injector <input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 200 mg SQ at Week 0 then 100mg at Week 2 <input type="checkbox"/> Maintenance Dose: Inject 100mg SQ every 4 weeks		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg/26mL solution single dose vial <input type="checkbox"/> 90mg/mL Prefilled Syringe Date of Initial Infusion: _____	<input type="checkbox"/> Loading Dose: Infuse: <input type="checkbox"/> 250mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg as initial IV dose as directed by prescriber <input type="checkbox"/> Maintenance Dose: Inject 90mg SC every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> Initiation Therapy – 600 mg/10 mL single use vial. <input type="checkbox"/> Ongoing Therapy – 360 mg/2.4 mL prefilled cartridge with On-Body Injector	<input type="checkbox"/> Initiation Therapy – <input type="checkbox"/> Inject 600 mg IV over at least 1 hour at Weeks 0, 4, 8. 1vial/week. <input type="checkbox"/> Ongoing Therapy – Week 12 – Inject 360 mg SC and every 8 weeks thereafter. 1 device with prefilled cartridge.		
<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"/> Loading Dose: <input type="checkbox"/> 10mg twice daily for 8 weeks <input type="checkbox"/> XR: 22mg once for 8 weeks <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 5mg twice daily <input type="checkbox"/> XR: 11mg once daily <input type="checkbox"/> 10mg twice daily <input type="checkbox"/> XR: 22mg once daily		

Prescriber Signature: _____ DAW (Dispense as Written) Y N Date: _____

If Century Specialty Script is the patient's choice, please Call-In, Fax or Mail prescriptions to:
 Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353