Crohn's and Ulcerative Colitis Enrollment Form

Date: _____

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

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
☐ 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 _____

Additional Information Therapy: ☐ 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
☐ Cimza	☐ 200mg/mL Vial Kit ☐ 200 mg/mL Starter Kit ☐ 200mg/mL prefilled Syringe	☐ **Loading Dose:** Inject 400mg SC at Weeks 0, 2, and 4 ☐ **Maintenance Dose:** Inject 200mg SC every 2 weeks		
☐ Entyvio	☐ 300mg vial	☐ **Loading Dose:** Inject 300mg IV over 30 minutes at Weeks 0, 2, and 6 ☐ **Maintenance Dose:** Infuse 300mg IV over 30 minutes every 8 weeks		
☐ Humira	**Starter Kits:** ☐ 80mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) **Maintenance:** ☐ 40mg/0.4mL Pre-Filled Pen (Citrate Free) ☐ 40mg/0.4mL Pre-Filled Syringe (Citrate Free) ☐ Other: _____	**Adult:** ☐ **Loading Dose:** Inject 160mg SC on Day 1, then 80mg on Day 15 (two weeks later) ☐ **Maintenance Dose:** Inject 40mg SC every other week (starting Day 29) **Pediatric (>6 years and adolescents) 17kg to < 40kg** ☐ **Loading Dose:** Inject 80mg SC on Day 1, 40mg on Day 15 (two weeks later) ☐ **Maintenance Dose:** Inject 20mg SC every other week (starting Day 29) **Pediatric (>6 years and adolescents) > 40kg** ☐ **Loading Dose:** Inject 160mg SC on Day 1, 80mg on Day 15 (two weeks later) ☐ **Maintenance Dose:** Inject 40mg SC every other week (starting Day 29)		

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:
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Lab Data _____
Prior Therapies _____
Concomitant Medications _____
Additional Comments _____
Injection Training Required? ☐ Yes ☐ No
PA# _____

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ 100mg Vial	☐ **Loading Dose:** Infuse 5mg/kg at Weeks 0, 2, and 6 ☐ **Maintenance Dose:** Infuse 5mg/kg every 8 weeks		
☐ Simponi	☐ 100mg/mL SmartJect Auto Injector ☐100mg/mL Prefilled Syringe	☐ **Loading Dose:** Inject 200mg SQ at Week 0 then 100mg at Week 2 ☐ **Maintenance Dose:** Inject 100mg SQ every 4 weeks		
☐ Stelara	☐ 130mg/26mL solution single dose vial ☐ 90mg/mL Prefilled Syringe Date of Initial Infusion: _____	☐ **Loading Dose:** Infuse: ☐ 250mg ☐ 390mg ☐ 520mg as initial IV dose as directed by prescriber ☐ **Maintenance Dose:** Inject 90mg SC every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
☐ Xeljanz	☐ 5mg tablet ☐ 10mg tablet ☐ 11mg XR tablet ☐ 22mg XR tablet	☐ **Loading Dose:** ☐ 10mg twice daily for 8 weeks ☐ XR: 22mg once for 8 weeks ☐ **Maintenance Dose:** ☐ 5mg twice daily ☐ XR: 11mg once daily ☐ 10mg twice daily ☐ XR: 22mg once daily		

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

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