Lumicera Health Services — Inflammatory Bowel Disease Enrollment Form

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Ship to: ○ Patient ○ Office ○ Other Date: Needs by Date:

PATIENT INFORMATION

Patient Name
Address
Address 2
City, State, ZIP
Preferred Phone Type
Alternate Phone Type
Email
DOB (mm/dd/yyyy) Gender ○ Male ○ Female

PRESCRIBER INFORMATION

Prescriber Name Specialty
State License # UPIN
DEA NPI
Group/Hospital
Address
City, State, ZIP
Phone Fax
Office Contact Phone

INSURANCE INFORMATION *(Please fax FRONT and BACK copy of all Insurance cards (Prescription and Medical)*

CLINICAL INFORMATION

Diagnosis (*Please include diagnosis name and ICD-10 code)*

Primary Diagnosis: ○ Crohn's Disease ○ Ulcerative Colitis

○ Other Diagnosis:

ICD-10:

Date of Diagnosis:

Weight: lbs/kgs | Height in/cm

Is the patient pregnant, nursing, or planning pregnancy?: ○ Yes ○ No ○ N/A

Date of last TB test (PPD or QuantiFERON Gold):

Results: ○ Positive ○ Negative

Allergies:

Concomitant medications:

Therapy: ○ New ○ Continuing Therapy ○ Restart

Has the patient been previously treated for this condition? ○ Yes ○ No

Prior failed medication (medication and duration of treatment/reason for d/c):

Who will administer injection? (if applicable):

Patient trained on injection? (if applicable): ○ Yes ○ No

Pharmacy injection training needed? (if applicable): ○ Yes ○ No

Additional comments:

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
○ Cimzia® (certolizumab pegol)	○ 200mg/ml prefilled syringe ○ 200mg lyophilized powder for reconstitution	○ 400mg subcutaneously at week zero, two and four (Loading dose) ○ 400mg every four weeks ○ 200mg every other week ○ Other:	6 2 2	0
○ Humira® (adalimumab)	○ 40mg/0.8ml prefilled syringe ○ 40mg/0.8ml pen	○ 160mg on day 1, 80mg on day 15, then 40mg every other week starting on day 29 (Crohn's/UC Starter Kit) ○ 40mg subcutaneously every other week ○ 40mg subcutaneously once weekly ○ Other:	6 2	0
○ Simponi® (golimumab)	○ 100mg/ml prefilled syringe ○ 100mg/ml SmartJect Autoinjector	○ 200mg subcutaneously at week 0, then 100mg at week 2 (Loading dose) ○ 100mg subcutaneously once monthly ○ Other:	3 1	0
○ Stelara® (ustekinumab)	○ 90mg/ml prefilled syringe	○ 90mg subcutaneously every 8 weeks, starting 8 weeks after IV induction ○ Date of last infusion:	1	
○ Xeljanz® (tofacitinib citrate)	○ 5mg tablet	○ 10mg by mouth twice daily ○ 5mg by mouth twice daily ○ Other:	120 60	

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: _____ Date ○ *PRODUCT SUBSTITUTION PERMITTED* ○ *DISPENSE AS WRITTEN*