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)	○ 10mg tablet ○ 5mg tablet	○ 10mg by mouth twice daily ○ 5mg by mouth twice daily ○ Other:______	60 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: ______ ______ ______

PRODUCT SUBSTITUTION PERMITTED *Date* *DISPENSE AS WRITTEN*