



VITAL CARE RX

Tailored Therapy, Trusted Care

Crohn's Disease/Ulcerative Colitis Enrollment Form

Phone: (877)229-1724 | Fax: (877)229-1725

PATIENT INFORMATION

(Complete the following or send patient demographic sheet.)
Please fax copy of patient's insurance card including both sides

Name: _____
DOB: _____ Gender: M / F Height: _____ Wt: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last 4 digits SS#: _____ Email: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State Lic. #: _____ NPI: _____
Facility Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact: _____
Phone: _____ Email: _____

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

K50.90 Crohn's disease NOS K51.90 Ulcerative Colitis Other: _____

Please indicate current or previous treatments and treatment duration below:

NSAIDS Duration: _____ Corticosteroids Duration: _____
 Methotrexate Duration: _____ Azathioprine Duration: _____
 Sulfasalazine Duration: _____ 5 – ASA Duration: _____
 6 – MP Duration: _____ Other: _____ Duration: _____

Other medications patient is currently taking: _____

TB/PPD Test given? Yes No Date: _____ Results: _____ Allergies: _____

BSA: _____

Expected date of first/next dose: _____ Date of last dose: _____

PRESCRIPTION INFORMATION

| Medication | Directions | Quantity | Refills |
|--|--|---------------|---------|
| Cimzia® <input type="checkbox"/> Starter Kit <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Lyophilized Powder | <input type="checkbox"/> Initial dose: Inject 400 mg SC at week 0, week 2, and week 4 <input type="checkbox"/> Maintenance dose: Inject 400 mg SC every 4 weeks | 1 starter kit | 0 |
| | | 28 day supply | |
| Entyvio® <input type="checkbox"/> 300 mg vial | <input type="checkbox"/> Initial Dose: Infuse 300mg IV over 30 minutes at week 0, week 2 and week 6 <input type="checkbox"/> Maintenance dose: Infuse 300mg IV over 30 minutes every 8 weeks | Initial dose | |
| | | QS | |
| Humira® <input type="checkbox"/> Starter Kit <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg Prefilled Syringe | <input type="checkbox"/> Initial Dose: Inject 160 mg (4 pens) SC on day 1, 80 mg (2 pens) on day 15, then 40 mg thereafter beginning on day 29 <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 40 mg SC once a week | 1 starter kit | 0 |
| | | 28 day supply | |
| Remicade® <input type="checkbox"/> 100 mg vial | <input type="checkbox"/> Initial Dose: Infuse _____ mg/kg (_____ mg) IV at weeks 0, 2, and 6 weeks. <input type="checkbox"/> Maintenance Dose: Infuse _____ mg/kg (_____ mg) IV every _____ weeks. | QS | |
| Simponi® <input type="checkbox"/> 100 mg SmartJect <input type="checkbox"/> 100 mg Prefilled Syringe | <input type="checkbox"/> Initial Dose: Inject 200mg SC at week 0, then 100mg at week 2, then maintenance dose <input type="checkbox"/> Maintenance Dose: Inject 100mg SC once every 4 weeks | 3 units | 0 |
| | | 28 day supply | |
| Stelara® <input type="checkbox"/> 130 mg vial <input type="checkbox"/> 90mg Prefilled Syringe | Initial Dose: Infuse IV over at least 1 hour. <input type="checkbox"/> ≤ 121 lbs 260 mg (2 vials) <input type="checkbox"/> > 121 lbs to 187 lbs 390 mg (3 vials) <input type="checkbox"/> > 187 lbs 520 mg (4 vials) <input type="checkbox"/> Maintenance Dose: Inject 90 mg SC 8 weeks after initial IV infusion, then every 8 weeks thereafter | QS | 0 |
| | | QS | |
| Other: | | | |

Special Instructions: _____

Ship Medications To: Physician's Clinic Patient's Home

Injection Training Needed: Yes No

Prescriber Signature _____ Date _____ Brand Name Required? Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.