Phone: 1-888-792-1552
Fax: 1-888-216-2510

To ePrescribe send prescription to:
Giant Eagle Pharmacy
20160 Center Ridge Road, Suite 201
Rocky River, OH 44116

CROHN'S DISEASE & ULCERATIVE COLITIS ENROLLMENT FORM

Today's Date: ____________________

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**______________ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: ______________________ ☐ Male ☐ Female DOB:____________________
Patient's First Name: ______________________________ Patient's Last Name: ______________________________
Address: ______________________________ City: ______________________ State: _____ ZIP: ______________
Best Phone Number: ______________________________ Alternate Phone Number: ______________________________
Best E-mail Address: ____
Height:__________ Weight: ____________ ☐ kgs. or ☐ lbs. Recorded Date: ____________________
Caregiver: ____ Allergies: ______________________________
Store Preference (address): ____
Emergency Contact Name: ________________________ Emergency Contact Phone #: ________________________

Insurance Information: Please fax copy of insurance card (front + back)

Prescription

MEDICATIONS	SIG.
☐ Humira® (adalimumab) ☐ Crohn's Starter Kit ☐ Pens ☐ Pre-filled Syringe	☐ Starter Package: 160mg (2x80mg) SQ on day 1, then 80mg (1x80mg) SQ on day 15 then 40 mg Qty: 3, Refill: 0 ☐ Maintenance Dose: 40mg SQ every other week Qty: ________ Refill: ________ ☐ Other: __________________ Qty: _________ Refill: ___________
☐ Simponi® (golimumab)	☐ Starter Package: 200mg/1mL week 0, 100mg/1mL week 2, Qty: 1, Refill: 0 ☐ Inject 100mg/1mL SQ every 4 weeks, Qty: _______ Refill: ________ ☐ Other: _____________ Qty: _______ Refill: ________
☐ Stelara® (ustekinumab)	Induction dosing (130mg/26ml vials): ☐ 260mg (2 vials) ☐ 390mg (3 vials) ☐ 520mg (4 vials) intravenously (IV) as a single dose ☐ Maintenance Dosing: ☐ 90mg SQ every 8 weeks; begin maintenance dosing 8 weeks after the IV iduction dose. Qty: ______ Refill: ______ ☐ Other: _____________ Qty: _______ Refill: ________
☐ Cimzia® (certolizumab pegol)	Induction dosing: ☐ 2x200mg/mL SubQ at weeks 0, 2 x 200 mg/mL at week 2 and week 4 Qty: 6 x 200 mg/mL - 3 Packs, Refill: 0 Maintenance Dosing (Select One): ☐ 2x200mg/mL SubQ every 4 weeks Qty: ______ Refill: ______ ☐ Other: ______________ Qty: ______ Refill: ______
☐ Remicade® (infliximab) ☐ Inflectra	☐ 5mg/kg (# _________100mg vials) Intravenously weeks 0, 2, and 6, then every 8 weeks thereafter ☐ Other:______________ Qty: ______ Refill: ______ ☐ Continuing: Dispense 5mg/kg (#______100 mg vials) intravenously every 8 weeks Refill: _____________
☐ Entyvio® (vedolizumab)	☐ Initiation: Dispense 3 vials of 300mg for IV infusion at weeks 0, 2, and 6 No Refills ☐ Continuing: Dispense 1 vial of 300mg for IV infusion every 8 week(s) Refill: ______
☐ Xeljanz®	☐ Take 10 mg by month twice daily ☐ Take 5 mg by month twice daily Qty: ______ Refill: ______

Medical Assessment

☐ Patient is New to Therapy ☐ Patient is currently on Therapy (Start Date: __________)
☐ Physician Provides Injection Training Injection/Infusion Date: ______________
Primary ICD-10 Code and Condition: ________________________________
Other ICD-10/Conditions: ________________________________
Date of Diagnosis: ________________________________
Current Weight: __________________ Date: ____________________
TB Test Results & Date: ________________________________
Hepatitis B Test Results and Date: ________________________________
☐ New Therapy Induction ☐ Therapy Change ☐ Remicade® Therapy Continuation
☐ Unresponsive to Conventional Treatment Weeks Completed ☐ 0 ☐ 2 ☐ 6
☐ Inadequate Response to Methotrexate Stop Date: __________
(Dose: ______________)
☐ Other Therapies Tried & Failed (Please List): ________________________________

Prior (FAILED) Medications:

	Medications	Date
Corticosteroids		
Methotrexate		
Azathioprine/6MP		
Sulfasalazine/Mesalamine		
Other Biologics		
Cyclosporine		
Other		

Additional justification for drug ________________

Prescriber Information

Date Prescription Needed: ____
Physician Name (please print): ______________________________ Contact Name: ______________________________
Phone #: ______________________ Fax #:______________________ NPI #: ______________________
Office Address: ______________________ City: ______________________ State: ________ ZIP: ________
State License #: ______________________________ DEA #: ______________________________
In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.
____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
Physician Signature: ____ **Date:** ____________________