Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

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:** ____________________