



Crohn's/Ulcerative Colitis Enrollment Form

Phone: 855-425-4085

Fax: 855-425-4096

ardonhealth.com

PATIENT INFORMATION and PRESCRIBER INFORMATION fields including Patient Name, Address, City, State, Zip, Primary Phone, DOB, Gender, Email, Last Four of SS #, Primary Language, Height, Weight, Prescriber's Name, State License #, NPI #, DEA #, Group or Hospital, Address, City, State, Zip, Phone, Fax, Contact Person, and Phone.

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL information fields including Need By Date, Ship to (Patient, Physician, Other), Date of Diagnosis, Diagnosis ICD-9 Code (Crohn's Disease, Ulcerative Colitis, Other), Previous Failed Medications, Current Medications, Allergies, Latex Allergy, Active/Serious Infection, Heart Failure, TB test, and new to therapy status.

PRESCRIPTION INFORMATION table with columns: MEDICATION, DOSE/STRENGTH, DIRECTIONS, QUANTITY, and REFILL. Includes checkboxes for Cimzia, Humira, Simponi, Stelara, and Remicade with their respective dosing instructions and quantities.

X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED
Ancillary supplies and kits will be provided as needed for administration.

X _____ (Date)
DISPENSE AS WRITTEN

Date Needed: _____ Medication Start Date: _____

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