ardon

Crohn's/Ulcerative Colitis Enrollment Form

Phone: 855-425-4085
Fax: 855-425-4096
ardonhealth.com

PATIENT INFORMATION

Patient Name:
Address:
City: State: Zip:
Primary Phone: DOB:
Alternate Phone: Gender: ☐ Male ☐ Female
Email:
Last Four of SS #: Primary Language:
Height: Weight:

PRESCRIBER INFORMATION

Prescriber's Name:
State License #: NPI #:
DEA #:
Group or Hospital:
Address:
City: State: Zip:
Phone: Fax:
Contact Person: Phone:

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

CLINICAL

Need By Date:	**Ship to**: ☐ Patient ☐ Physician ☐ Other:
Date of Diagnosis:	**Diagnosis ICD-9 Code: Crohn's Disease** ☐ 555.9 **Ulcerative Colitis** ☐ 556.9 **Other (ICD-9 Code)** ☐
Previous Failed Medications:	
Current Medications:	
Allergies:	**Latex Allergy?** ☐ Yes ☐ No
Does patient have Active/Serious Infection? ☐ Yes ☐ No	**Does patient have Heart Failure?** ☐ Yes ☐ No
Has patient had a positive TB test? ☐ **Yes** ☐ **No** If Yes, Date of last Chest X-Ray:	**Is the patient new to therapy?** ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ **Cimzia**	☐ Starter Kit ☐ 200mg/ml PFS ☐ 200mg Vial	☐ **Induction Dose**: Inject 400mg SQ on day 1, 15, and 29 ☐ **Maintenance Dose**: Inject 400mg SQ every 4 weeks	☐ 1 Starter Kit = 6 PFS ☐ 2	
☐ **Humira**	☐ Crohn's/UC Starter Pack ☐ 40mg Self-Injectable Pen ☐ 40mg PFS	☐ **Induction Dose**: Inject 160mg (4 pens) SQ on day 1, 80mg (2 pens) SQ on day 15, then maintenance dosing ☐ **Maintenance Dose:** Inject 40mg SQ every 14 days ☐ **Maintenance Dose:** Inject 40mg SQ every 7 days	☐ 1 Starter Kit = 6 Pens ☐ 2 ☐ 4	
☐ **Simponi**	☐ 100mg/ml SmartJect ☐ 100mg/ml PFS	☐ **Induction Dose**: Inject 200mg SQ day 1, then 100mg SQ on day 15, then 100mg every 4 weeks thereafter ☐ **Maintence Dose:** Inject 100mg SQ every 28 days ☐ **Other:**	☐ 3 x 100mg Pens/PFS ☐ 1 x 100mg Pens/PFS	
☐ **Stelara**	☐ 90mg PFS	☐ **Maintenance Dose:** Inject _____mg SQ every 56 days	☐ 1 PFS	
☐ **Remicade**	☐ 100mg Vial	☐ Induction: Infuse _____mg IV at weeks 0, 2, and 6 ☐ Maintenance: Infuse _____mg IV very 8 weeks	☐ _____ # Vial(s)	
☐			____	

X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED

X _____ (Date)
DISPENSE AS WRITTEN

Ancillary supplies and kits will be provided as needed for administration.

PHYSICIAN SIGNATURE REQUIRED

Date Needed: _____ Medication Start Date: _____