

# Crohn's/Ulcerative Colitis enrollment form



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

Date needed	Medication start date	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other:
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Patient information					
Patient name	Date of birth		Phone	Alternate phone	
Address		City	State	ZIP	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email	Primary language		Height	Weight

Prescriber information					
Prescriber name		State License #	NPI #	DEA #	
Group or hospital		Address	City	State	ZIP
Phone	Fax	Contact person name and phone			

**Insurance information:** If available, please fax a copy of the prescription and insurance card(s) with this form (front and back).

Clinical	
Date of diagnosis	Diagnosis ICD-10 code: <input type="checkbox"/> K50.90 Crohn's Disease <input type="checkbox"/> K51.90 Ulcerative Colitis <input type="checkbox"/> Other (ICD-10 Code) _____
Previous medications:	Current medications:
Does the patient have a latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient also taking methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have active/serious infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies:
Does patient have heart failure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient had positive TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, date of last chest x-ray</i> _____	

Prescription information				
Medication	Dose/strength	Directions	Quantity	Refill
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit (200 mg/mL Prefilled Syringes)	<input type="checkbox"/> Induction Dose: Inject 400 mg SUBQ on day 1, 15, and 29	<input type="checkbox"/> 1 Starter Kit = 6 PFS	0
	<input type="checkbox"/> 200 mg/mL Prefilled Syringe <input type="checkbox"/> 200 mg Vial	<input type="checkbox"/> Maintenance Dose: Inject 400 mg SUBQ every 28 days	<input type="checkbox"/> 2 PFS/Vials	
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 300 mg/2 mL Pen <input type="checkbox"/> 300 mg/2 mL Prefilled Syringe	<input type="checkbox"/> Inject 300 mg SUBQ every 7 days	<input type="checkbox"/> 4 Pens/PFS	
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 108 mg/0.6 mL Pen	<input type="checkbox"/> Maintenance Dose: Inject 108 mg SUBQ at week 6, followed by every 2 weeks thereafter Has the patient received the IV induction doses already? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, date of IV induction doses:</i> Week 0: _____ Week 2: _____	<input type="checkbox"/> 2 Pens	

Physician signature required	
Product substitution permitted <input checked="" type="checkbox"/> _____ Date _____	Dispense as written <input checked="" type="checkbox"/> _____ Date _____

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

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<input type="checkbox"/> Humira®	<input type="checkbox"/> 40 mg/0.8 mL Pen Crohn's Disease, Ulcerative Colitis Starter (6 pens)	<input type="checkbox"/> Adult Crohn's/UC and Pediatric Crohn's (≥ 40 kg) Induction Dose: Inject 160 mg SUBQ on day 1, 80 mg on day 15, then 40 mg every 14 days thereafter starting on day 29	<input type="checkbox"/> 1 Kit	0
	<input type="checkbox"/> 40 mg/0.8 mL Prefilled Syringe Pediatric Crohn's Disease Starter (6 syringes)			
	<input type="checkbox"/> 40 mg/0.8 mL Prefilled Syringe Pediatric Crohn's Disease Starter (3 syringes)	<input type="checkbox"/> Pediatric Crohn's (17 to < 40 kg) Induction Dose: Inject 80 mg SUBQ on day 1, 40 mg on day 15, then 20 mg every 14 days starting on day 29		
	<input type="checkbox"/> 40 mg/0.8 mL Pen	<input type="checkbox"/> Inject 40 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 40 mg/0.8 mL Prefilled Syringe	<input type="checkbox"/> Inject 40 mg SUBQ every 7 days	<input type="checkbox"/> 4 Pens/PFS	
	<input type="checkbox"/> 20 mg/0.4 mL Prefilled Syringe	<input type="checkbox"/> Inject 20 mg SUBQ every 14 days	<input type="checkbox"/> 2 PFS	
		<input type="checkbox"/> Inject 20 mg SUBQ every 7 days	<input type="checkbox"/> 4 PFS	
<input type="checkbox"/> Humira® (Citrate-free)	<b>Starter Dose</b>			
	<input type="checkbox"/> 80 mg/0.8 mL Pen Crohn's Disease, Ulcerative Colitis Starter (3 pens)	<input type="checkbox"/> Adult Crohn's/UC and pediatric Crohn's (≥ 40 kg): Inject 160 mg SUBQ on day 1, 80 mg on day 15, then 40 mg every 14 days thereafter starting on day 29	<input type="checkbox"/> 1 Kit	0
	<input type="checkbox"/> 40 mg/0.4 mL Pen Crohn's Disease, Ulcerative Colitis Starter (6 pens)			
	<input type="checkbox"/> 80 mg/0.8 mL Prefilled Syringe Pediatric Crohn's Disease Starter (3 syringes)			
	<input type="checkbox"/> 80 mg/0.8 mL and 40 mg/0.4 mL Prefilled Syringe Pediatric Crohn's Disease Starter (2 syringes)	<input type="checkbox"/> Pediatric Crohn's (17 to < 40 kg) Induction Dose: Inject 80 mg SUBQ on day 1, 40 mg on day 15, then 20 mg every 14 days starting on day 29		
	<input type="checkbox"/> 80 mg/0.8 mL Pen Pediatric Ulcerative Colitis Starter (4 pens)	<input type="checkbox"/> Pediatric UC (≥ 40 kg) Induction Dose: Inject 160 mg SUBQ on day 1, 80 mg on day 15, then begin maintenance dosing starting on day 29		
	<input type="checkbox"/> 40 mg/0.4 mL Prefilled Syringe Pediatric Ulcerative Colitis (4 syringes)	<input type="checkbox"/> Pediatric UC (20 kg to < 40 kg) Induction Dose: Inject 80 mg SUBQ on day 1, 40 mg on day 8, 40 mg on day 15, then begin maintenance dosing starting on day 29		
	<input type="checkbox"/> 40 mg/0.4 mL Pen Pediatric Ulcerative Colitis (4 pens)			
<b>Maintenance Dose</b>				
<input type="checkbox"/> 80 mg/0.8 mL CF Pen	<input type="checkbox"/> Inject 80 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens		
<input type="checkbox"/> 40 mg/0.4 mL CF Pen	<input type="checkbox"/> Inject 40 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens/PFS		
<input type="checkbox"/> 40 mg/0.4 mL CF Prefilled Syringe	<input type="checkbox"/> Inject 40 mg SQ every 7 days	<input type="checkbox"/> 4 Pens/PFS		
	<input type="checkbox"/> Inject 20 mg SUBQ every 14 days	<input type="checkbox"/> 2 PFS		
	<input type="checkbox"/> Inject 20 mg SUBQ every 7 days	<input type="checkbox"/> 4 PFS		
<input type="checkbox"/> Omvoh®	<input type="checkbox"/> 100 mg/mL Pen <input type="checkbox"/> 100 mg/mL Prefilled Syringe	<input type="checkbox"/> Ulcerative Colitis Maintenance Dose: Inject 200 mg SUBQ at Week 12, followed by every 4 weeks thereafter  Has the patient received the IV induction doses already? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of IV induction doses: Week 0: _____ Week 4: _____ Week 8: _____	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 1 x 100 mg/mL Pen and 1 x 200 mg/2 mL Pen <input type="checkbox"/> 1 x 100 mg/mL Prefilled Syringe and 1 x 200 mg/2 mL Prefilled Syringe	<input type="checkbox"/> Crohn's Disease Maintenance Dose: Inject 300 mg SUBQ at Week 12, followed by every 4 weeks thereafter  Has the patient received the IV induction doses already? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of IV induction doses: Week 0: _____ Week 4: _____ Week 8: _____	<input type="checkbox"/> 2 Pens/PFS	
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> Induction Dose: Infuse _____ mg IV at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: Infuse _____ mg IV every 8 weeks	____ vial(s) ____ vial(s)	0
<input type="checkbox"/> Rinvoq®	<input type="checkbox"/> 45 mg XR Tablet	<input type="checkbox"/> Ulcerative Colitis Induction Dose: Take 1 tablet by mouth once daily for 8 weeks <input type="checkbox"/> Crohn's Disease Induction Dose: Take 1 tablet by mouth once daily for 12 weeks	<input type="checkbox"/> 28 Tablets <input type="checkbox"/> 28 Tablets	1 2
	<input type="checkbox"/> 15 mg XR Tablet	<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth once daily	<input type="checkbox"/> 30 Tablets	
	<input type="checkbox"/> 30 mg XR Tablet			

**Physician signature required**

**Product substitution permitted**

X \_\_\_\_\_ Date \_\_\_\_\_

**Dispense as written**

X \_\_\_\_\_ Date \_\_\_\_\_

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<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg/mL Pen <input type="checkbox"/> 100 mg/mL Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 200 mg SUBQ day 1, then 100 mg on day 15, then 100 mg every 28 days thereafter <input type="checkbox"/> Maintenance Dose: Inject 100 mg SUBQ every 28 days	<input type="checkbox"/> 3 Pens/PFS <input type="checkbox"/> 1 Pen/PFS	0
<input type="checkbox"/> Skyrizi®	<input type="checkbox"/> 180 mg/1.2 mL prefilled cartridge with on-body injector <input type="checkbox"/> 360 mg/2.4 mL prefilled cartridge with on-body injector	<input type="checkbox"/> Maintenance Dose: Inject 180 mg SUBQ at week 12, followed by every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 360 mg SUBQ at week 12, followed by every 8 weeks thereafter Has the patient received the IV induction doses already? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of IV induction doses: Week 0: _____ Week 4: _____ Week 8: _____	<input type="checkbox"/> 1 Kit	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 90 mg Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 90 mg SUBQ 8 weeks after initial IV dose, followed by every 8 weeks thereafter Has the patient received the IV induction dose already? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of IV induction dose: _____	<input type="checkbox"/> 1 PFS	
<input type="checkbox"/> Tremfya®	<input type="checkbox"/> Induction Pack for Crohn's Disease and Ulcerative Colitis (200 mg/2 mL Pens) <input type="checkbox"/> 100 mg/mL Pen <input type="checkbox"/> 100 mg/mL Prefilled Syringe <input type="checkbox"/> 200 mg/2 mL Pen <input type="checkbox"/> 200 mg/2 mL Prefilled Syringe	<input type="checkbox"/> Crohn's Disease and Ulcerative Colitis Induction Dose: Inject 400 mg SUBQ at week 0, 4 and 8 <input type="checkbox"/> Maintenance Dose: Inject 100 mg SUBQ at week 16, followed by every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 200 mg SUBQ at week 12, followed by every 4 weeks thereafter If not receiving SUBQ induction for Crohn's Disease or Ulcerative Colitis, has the patient received the IV induction doses already? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If yes, date of IV induction doses: Week 0: _____ Week 4: _____ Week 8: _____	<input type="checkbox"/> 1 Pack = 2 Pens <input type="checkbox"/> 1 Pen/PFS	2
<input type="checkbox"/> Velsipity®	<input type="checkbox"/> 2 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 30	
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 10 mg Tablet	<input type="checkbox"/> Induction Dose: Take 1 tablet by mouth 2 times daily for at least 8 weeks (if needed, continue for a maximum of 16 weeks)	<input type="checkbox"/> 60 Tablets	
	<input type="checkbox"/> 5 mg Tablet	<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth 2 times daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 60 Tablets	
	<input type="checkbox"/> 22 mg XR Tablet	<input type="checkbox"/> Induction Dose: Take 1 tablet by mouth once daily for at least 8 weeks (if needed, continue for a maximum of 16 weeks)	<input type="checkbox"/> 30 Tablets	
	<input type="checkbox"/> 11 mg XR Tablet	<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth once daily	<input type="checkbox"/> 30 Tablets	
<input type="checkbox"/> Zeposia®	<input type="checkbox"/> Titration Pack (7-day) <input type="checkbox"/> Titration Pack (28-day)	<input type="checkbox"/> Titration Dose: 0.23 mg by mouth once daily on day 1-4, 0.46 mg once daily on day 5-7, followed by 0.92 mg once daily thereafter	<input type="checkbox"/> 1 Titration Kit	NA
	<input type="checkbox"/> 0.92 mg Capsule	<input type="checkbox"/> Take 1 tablet by mouth daily	<input type="checkbox"/> 30 Tablets	
<input type="checkbox"/> Zymfentra®	<input type="checkbox"/> 120 mg/mL Pen <input type="checkbox"/> 120 mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 120 mg SUBQ at week 10, followed by every 2 weeks thereafter Has the patient received the IV induction doses already? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of IV induction doses: Week 0: _____ Week 2: _____ Week 6: _____	<input type="checkbox"/> 2 Pens/PFS	

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X \_\_\_\_\_ Date \_\_\_\_\_

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