

Crohn's and Ulcerative Colitis Enrollment Form

Y Medical Associates
Fax Referral To: 855-838-0623
Phone: 800-447-7558



Date: _____

Patient Information

Please complete the following or send patient demographic sheet

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 DOB: _____ Gender: M F

Prescriber Information

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 DEA: _____ NPI#: _____
 Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
 Secondary Insurance: _____ ID#: _____ Group: _____
 Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Medical Information (Section must be completed to process prescription) (Attach separate sheet if needed)

Prior Authorization Insurance Number: _____

Diagnosis - Please include diagnosis name with ICD-10 code

- K50.00 Crohn's disease of small intestines without complications
 - K50.8 Crohn's disease of both intestines without complications
 - K50.10 Crohn's disease of large intestines without complications
 - K50.00 Crohn's disease, unspecified, without complications
 - K20.0 Eosinophilic Esophagitis
 - Other diagnosis: ICD-10 code _____
- Description _____ Date of Description _____
 Has a TB test been performed? Yes No
 Does the Patient have an active infection? Yes No
 Start Date _____ Review Date _____

Therapy Details: New Reauthorization Restart


Weight _____ kg/lbs Height _____ cm/in
 Allergies _____
 Lab Data _____
 Prior Therapies _____
 Concomitant Medications _____
 Additional Comments _____
 Injection Training Required? Yes No

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/mL Vial Kit <input type="checkbox"/> 200mg/mL Starter Kit <input type="checkbox"/> 200mg/mL prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 400mg SC at Weeks 0, 2, and 4 <input type="checkbox"/> Maintenance Dose: Inject 200mg SC every 2 weeks		
<input type="checkbox"/> Dupixent	<input type="checkbox"/> PFS with needle shield 300 mg/2 mL <input type="checkbox"/> Prefilled Pen 300 mg/2 mL	<input type="checkbox"/> Inject 300 mg Sub Q every week		
<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> Loading Dose: Inject 300mg IV over 30 minutes at Weeks 0, 2, and 6. <input type="checkbox"/> Maintenance Dose: Infuse 300mg IV over 30 minutes every 8 weeks		
<input type="checkbox"/> Humira	Starter Kits: <input type="checkbox"/> 80mg/0.8mL Starter Pack Pre-Filled Pen (Citrate Free) Maintenance: <input type="checkbox"/> 40mg/0.4mL Pre-Filled Pen (Citrate Free) <input type="checkbox"/> 40mg/0.4mL Pre-Filled Syringe (Citrate Free) <input type="checkbox"/> Other: _____	Adult: <input type="checkbox"/> Loading Dose: Inject 160mg SC on Day 1, then 80mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week (starting Day 29) Pediatric (>6 years and adolescents) 17kg to < 40kg <input type="checkbox"/> Loading Dose: Inject 80mg SC on Day 1, 40mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 20mg SC every other week (starting Day 29) Pediatric (>6 years and adolescents) > 40kg <input type="checkbox"/> Loading Dose: Inject 160mg SC on Day 1, 80mg on Day 15 (two weeks later) <input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week (starting Day 29)		

Prescriber Signature: _____ DAW (Dispense as Written) Y N Date: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intend recipient, please notify us immediately by calling or faxing back to the originator.

Crohn's and Ulcerative Colitis Enrollment Form	Y Medical Associates Fax Referral To: 855-838-0623 Phone: 800-447-7558	
Date: _____		

Patient Information	Prescriber Information
Please complete the following or send patient demographic sheet Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA: _____ NPI#: _____ Contact Person: _____

Insurance Information	
Primary Insurance: _____ ID#: _____ Group: _____	Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____	BIN#: _____ PCN#: _____ Group: _____

Medical Information (Section must be completed to process prescription)	(Attach separate sheet if needed)
---	-----------------------------------

Prior Authorization Insurance Number: _____	
Diagnosis - Please include diagnosis name with ICD-10 code <input type="checkbox"/> K50.00 Crohn's disease of small intestines without complications <input type="checkbox"/> K50.8 Crohn's disease of both intestines without complications <input type="checkbox"/> K50.10 Crohn's disease of large intestines without complications <input type="checkbox"/> K50.00 Crohn's disease, unspecified, without complications <input type="checkbox"/> Other diagnosis: ICD-10 code _____ Description _____ Date of Description _____ Has a TB test been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the Patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date _____ Review Date _____	Therapy Details: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart Weight _____ kg/lbs Height _____ cm/in Allergies _____ Lab Data _____ Prior Therapies _____ Concomitant Medications _____ Additional Comments _____ Injection Training Required? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescription Information				
--------------------------	--	--	--	--

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Loading Dose: Infuse 5mg/kg at Weeks 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: Infuse 5mg/kg every 8 weeks		
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> Induction Therapy – 45 mg tablet <input type="checkbox"/> Maintenance Therapy – 15 mg or 30 mg tablets	<input type="checkbox"/> Induction Therapy: 45 mg PO daily x 8 weeks. Maintenance Therapy: <input type="checkbox"/> 15 mg PO daily <input type="checkbox"/> 30 mg PO daily		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100mg/mL SmartJect Auto Injector <input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 200 mg SQ at Week 0 then 100mg at Week 2 <input type="checkbox"/> Maintenance Dose: Inject 100mg SQ every 4 weeks		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg/26mL solution single dose vial <input type="checkbox"/> 90mg/mL Prefilled Syringe Date of Initial Infusion: _____	<input type="checkbox"/> Loading Dose: Infuse: <input type="checkbox"/> 250mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg as initial IV dose as directed by prescriber <input type="checkbox"/> Maintenance Dose: Inject 90mg SC every 8 weeks (begin dosing 8 weeks after the IV induction dose)		
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> Initiation Therapy – 600 mg/10 mL single use vial. <input type="checkbox"/> Ongoing Therapy – 360 mg/2.4 mL prefilled cartridge with On-Body Injector	<input type="checkbox"/> Initiation Therapy – <input type="checkbox"/> Inject 600 mg IV over at least 1 hour at Weeks 0, 4, 8. 1 vial/week. <input type="checkbox"/> Ongoing Therapy – Week 12 – Inject 360 mg SC and every 8 weeks thereafter. 1 device with prefilled cartridge.		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet <input type="checkbox"/> 11mg XR tablet <input type="checkbox"/> 22mg XR tablet	<input type="checkbox"/> Loading Dose: <input type="checkbox"/> 10mg twice daily for 8 weeks <input type="checkbox"/> XR: 22mg once for 8 weeks <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 5mg twice daily <input type="checkbox"/> XR: 11mg once daily <input type="checkbox"/> 10mg twice daily <input type="checkbox"/> XR: 22mg once daily		

Prescriber Signature: _____ DAW (Dispense as Written) <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intend recipient, please notify us immediately by calling or faxing back to the originator.