USspecialty
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CROHN'S DISEASE AND ULCERATIVE COLITIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.usspecialtycare.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient:_____ Caregiver: _____

DOB:_____ ☐ Male ☐ Female Weight:_____ ☐ kgs or ☐ lbs (check one) Height_____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address:_____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies:_____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

PRIOR HISTORY:	PRIOR BIOLOGIC USE:	DATE OF LAST DOSE:
☐ 5-ASA	☐ Remicade®	_____
☐ Immunosuppressants (6-MP or other)	☐ Humira®	_____
☐ Corticosteroids	☐ Cimzia®	_____
☐ Methotrexate	☐ Other_____	_____
☐ Surgery		
☐ Other _____		

PRIOR (FAILED) THERAPY:

Does the patient have an active infection? Yes ☐ No ☐

Does the patient require injection training? Yes ☐ No ☐

Does patient have a Negative TB test result ? Yes ☐ No ☐

Date of Test: _____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Humira® (adalimumab) ☐ Enroll in Humira® Complete	Starter Dose: ☐ 6 x 40mg/o.8ml.	☐ 160 mg Sub-Q Day 1, 80 mg Day 15, 40 mg Day 29 and every other week thereafter	☐ 1 Kit = 6 x 40 mg Pens ☐ 3 Cartons = 6 x 40 mg **PFS**	0
	Maintenance Dose: ☐ 40 mg Pens ☐ 40 mg Prefilled Syringes (PFS)	☐ 40 mg Sub-Q every other week ☐ 40 mg Sub-Q once weekly	☐ 1 Carton = 2 x 40 mg Pens ☐ 1 Carton = 2 x 40 mg PFS ☐ 2 Cartons = 4 x 40 mg Pens ☐ 2 Cartons = 4 x 40 mg PFS	_____
Entyvio® (vedolizumab) ☐ Enroll in EntyvioConnect	☐ 300mg Single Use Vial	Starter Dose: ☐ Infuse 300 mg intravenously over 30 minutes at week 0, 2, and 6	3 Vials	0
		Maintenance Dose: ☐ Infuse 300 mg intravenously over 30 minutes every 8 weeks	1 Vial	_____
Stelara® (ustekinumab) ☐ Enroll in CarePath®	Starter Dose IV: ☐ 2 Vials of 130 mg/26 mL IV ☐ 3 Vials of 130 mg/26 mL IV ☐ 4 Vials of 130 mg/26 mL IV	☐ 55 kg or less – Infuse 260 mg single dose over at least 1 hour ☐ 56 kg to 85 kg – Infuse 390 mg single dose over at least 1 hour ☐ more than 85 kg – Infuse 520 mg single dose over at least 1 hour	☐ _____ Total amount of single use vials	0
	Maintenance Dose: 90 mg Prefilled Syringe	☐ Inject 90 mg SQ 8 weeks after the initial IV starter dose **then** ☐ 90 mg every 8 weeks thereafter	90 mg Prefilled Syringe Qnty: _____	_____
Remicade® (infliximab) ☐ Inflectra ☐ Renflexis ☐ Enroll in CarePath®	☐ 100 mg Lyophilized Vials (LYO)	Starter Dose: ☐ 5 mg/kg IV at weeks 0, 2 and 6	☐ _____ Vial(s)	0
		Maintenance Dose: ☐ 5 mg/kg IV every 8 weeks	☐ _____ Vial(s)	_____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Cimzia® (certolizumab) ☐ Enroll in Cimzia® Connect	Starter Dose: ☐ Cimzia Starter Kit (Prefilled Syringes) ☐ 200 mg Lyophilized Vials (LYO)	☐ 400 mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200 mg/mL PFS ☐ 3 Cartons = 6 x 200 mg Vials (LYO)	0
	Maintenance Dose: ☐ 200 mg/mL Prefilled Syringes ☐ 200 mg Lyophilized Vials (LYO)	☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200 mg/mL PFS ☐ 1 Carton = 2 x 200 mg Vials (LYO)	_____
Simponi® (golimumab) ☐ Enroll in Janssen CarePath®	Starter Dose: ☐ 3 x 100mg/ml	☐ Inject 200 mg SQ at week 0, **then** 100 mg at week 2	☐ SmartUext Autoinjector® **OR** ☐ PFS	0
	Maintenance Dose: ☐ 1 x 100mg/ml	☐ Inject 100 mg SQ every 4 weeks	☐ SmartUext Autoinjector® **OR** ☐ PFS	_____
Other				

INJECTION TRAINING: ☐ **OFFICE TO COORDINATE** ☐ **USSC TO COORDINATE**

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____

Fax #: _____Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

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☐ I understand that USSC may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: _____Prescriber's Signature: _____Date: _____

☐ Use substitution ☐ Dispense as Written