PHARMACA
SPECIALTY PHARMACY

INFLAMMATORY BOWEL DISEASE ENROLLMENT FORM

Fax: **888-882-3341**
Call 24/7: **855-465-8892**

1 PATIENT INFORMATION:

Name: ______________________
Address: ______________________
City: ____________ State: _____ Zip: ________
Phone: ____________ Alt Phone: ____________
Email: ______________________
DOB: __________ ☐ M ☐ F Last 4 of SSN: ________

2 PRESCRIBER INFORMATION:

Name: ______________________
Address: ______________________
City: ____________ State: _____ Zip: ________
Phone: ____________ Fax: ____________
NPI: ____________ DEA: ____________
Office Contact: ____________ Phone: ____________

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: ________ Drug Allergies: ☐ NKDA ☐ ______________________

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: ______________________

5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: ____________

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: ____________

PRESCRIPTION INFORMATION:

Medication	Dose/Strength	Directions	Qty	Refills
☐ **Cimzia®**	☐ Prefilled Syringe Starter Kit ☐ 200mg/ml Prefilled Syringe ☐ 200mg Lyophilized Powder Vial	☐ **Induction:** Inject 400mg SC on day 1, day 14 and day 28	6	0
		☐ **Maintenance:** Inject 400mg SC every 4 weeks	2	
☐ **Humira®**	☐ Crohn's/Ulcerative Colitis Starter Kit ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ **Induction:** Inject 160mg SC on day 1, then 80mg SC on day 15, then switch to maintenance dose	6	0
		☐ **Maintenance:** Inject 40mg SC every other week	2	
☐ **Simponi®**	☐ 100mg/ml SmartJect® Autoinjector ☐ 100mg/ml Prefilled Syringe	☐ **Induction:** Inject 200mg SC at week 0, 100mg SC at week 2, then switch to maintenance dose	3	0
		☐ **Maintenance:** Inject 100mg SC every 4 weeks	1	
☐ **Stelara®**	☐ 130mg/26ml Vial ☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/ml Prefilled Syringe ☐ 45mg/0.5ml Vial	☐ **Induction:** Administer ________mg IV for initial dose		0
		☐ **Maintenance:** Inject 90mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	1	
☐ **Uceris®**	☐ 9mg Tablets	☐ Take one tablet daily in the morning with or without food	30	
☐ **Xeljanz®**	☐ 5mg Tablets ☐ 10mg Tablets	☐ **Induction:** Take 10mg by mouth twice daily for 8 weeks		
		☐ **Maintenance:** Take 5mg by mouth twice daily ☐ **Maintenance:** Take 10mg by mouth twice daily		
☐ **Xifaxan®**	☐ 550mg Tablets	☐ Take one tablet by mouth three times daily for 14 days	42	
☐	☐	☐		

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

PHYSICIAN SIGNATURE REQUIRED

X ______________________ X ______________________
Substitution Permitted Date Dispense as Written Date

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