PHARMACA®
SPECIALTY PHARMACY

INFLAMMATORY BOWEL DISEASE ENROLLMENT FORM

Fax: **888.882.3341**
Call: **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 and Form	Directions	Qty	Refills
☐ **Cimzia**	☐ Prefilled Syringe Starter Kit ☐ 200 mg/mL Prefilled Syringe ☐ 200 mg Lyophilized Powder Vial	☐ **Induction:** Inject 400 mg SC on day 1, day 14 and day 28	6	0
		☐ **Maintenance:** Inject 400 mg SC every 4 weeks	2	
☐ **Humira**	☐ Crohn's/Ulcerative Colitis Starter Kit ☐ 40 mg/0.8mL Pen ☐ 40 mg/0.8mL Prefilled Syringe	☐ **Induction:** Inject 160 mg SC on day 1, then 80 mg SC on day 15, then switch to maintenance dose	6	0
		☐ **Maintenance:** Inject 40 mg SC every other week	2	
☐ **Simponi**	☐ 100 mg/mL SmartJect Autoinjector ☐ 100 mg/mL Prefilled Syringe	☐ **Induction:** Inject 200 mg SC at week 0, 100 mg SC at week 2, then switch to maintenance dose	3	0
		☐ **Maintenance:** Inject 100 mg SC every 4 weeks	1	
☐ **Stelara**	☐ 130 mg/26mL Vial ☐ 45 mg/0.5mL Prefilled Syringe ☐ 90 mg/mL Prefilled Syringe ☐ 45 mg/0.5mL Vial	☐ **Induction:** Administer ________ mg IV for initial dose		0
		☐ **Maintenance:** Inject 90 mg SC 8 weeks after the initial intravenous dose, then every 8 weeks thereafter	1	
☐ **Uceris**	☐ 9m g Tablets	☐ Take one tablet daily in the morning with or without food	30	
☐ **Xeljanz**	☐ 5 mg Tablets ☐ 10 mg Tablets	☐ **Induction:** Take 10 mg by mouth twice daily for 8 weeks		
		☐ **Maintenance:** Take 5 mg by mouth twice daily ☐ **Maintenance:** Take 10 mg by mouth twice daily		
☐ **Xifaxan**	☐ 550 mg 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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