Crohn's & Ulcerative Colitis Enrollment Form

Today's Date: _____

VitalityRx Specialty Pharmacy

Fax Form to 516-464-2520

vitalityrx

Patient Information:

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Sex: ___ M ___ F

Emergency Contact:

Name: _____

Relationship: _____ Phone: _____

Prescriber Information:

Name/Title: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

NPI: _____

Contact Person: _____

Extension (if applicable): _____

Insurance Information (Please attach copies of the front and back of insurance and prescription drug cards):

Primary Insurance: _____ ID#: _____ Group: _____

Secondary Insurance: _____ ID#: _____ Group: _____

Rx Coverage: _____ ID#: _____ BIN: _____ PCN: _____ Grp: _____

Diagnosis Codes (ICD 10):

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

Description: _____ Description: _____ Description: _____

Clinical Information: (Please attach lab results, medical history documents, and other relevant clinical information)

Weight: _____ kg / lb Height: _____ cm / in Allergies: _____

Has patient previously received treatment for this condition? ☐ No ☐ Yes: _____

Date of last dose: _____ Next dose due: _____

Comorbid Conditions: ☐ Renal Dysfunction ☐ Liver Dysfunction ☐ CHF – NYHA Class: ☐ I-II ☐ III-IV ☐ Active Infection

Current Medications: _____

AST Level: _____ ALT Level: _____ Has a TB test been done? ☐ Yes ☐ No Date Collected: _____

Prescription Information:

DRUG	DOSAGE FORM	DIRECTIONS	QUANTITY	REFILLS
☐ Stelara (ustekinumab)	☐ IV: 130mg/26mL vial ☐ SQ: 90mg/1mL PFS (pre-filled syringe)	☐ Loading Dose: Infuse ☐ 260mg ☐ 390mg ☐ 520mg as initial single-dose IV induction dose ☐ Maintenance Dose: Inject 90mg SQ every 8 weeks (begin dosing 8 weeks after IV induction)	_____ ☐ vials ☐ PFS	
☐ Entyvio (vedolizumab)	☐ IV: 300mg vial	☐ Loading Dose: Infuse 300mg IV over 30 minutes at weeks 0, 2, and 6 ☐ Maintenance: Infuse 300mg IV over 30 minutes every 8 weeks	_____ vials	
☐ Remicade (infliximab)	☐ IV: 100mg vial	☐ Loading Dose: Infuse ☐ 5mg/kg ☐ 10mg/kg IV over 2 hours at weeks 0, 2, and 6 ☐ Maintenance Dose: Infuse ☐ 5mg/kg ☐ 10mg/kg IV over 2 hours every 8 weeks	_____ vials	

Site of care: ☐ Home Administration ☐ Prescriber's Office ☐ Infusion Suite _____

Needs by date: _____ Deliver to: _____

Are there any functional limitations or mental limitations (reasoning, judgment, memory, etc.) that can hinder access to therapy or affect compliance? ☐ No ☐ Yes: _____

Are there any limitations identified in the patient's social determinants of health (living situation, transportation, access to food, etc.)? ☐ No ☐ Yes: _____

By signing below, I certify that above therapy is medically necessary.

Prescriber Signature: Date: Dispense as Written? ☐ Yes ☐ No