



**Crohn's Disease Enrollment Form
Patient Referral/Medication Request Form**

Phone: 806-324-5447 • Toll Free Phone 1-866-629-6779 • Toll Free Fax: 1-866-217-8034

Patient Information

Patient Name _____

Date of Birth _____ Male Female

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone Home _____

Work _____ Cell _____

Social Security # _____

Allergies _____ NKA

Weight _____ kg lb Blood Pressure _____

Emergency Contact Name _____

Phone _____

Please attach copy of insurance information or copy of insurance cards (both sides).

Shipping Information

Patient's Home Physician's Office

Other _____

Date Medication Needed _____

Physician Information

Physician Name _____

Office Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Physician Signature _____

Date _____

Dispense as written Generic substitution permitted

Diagnosis/Medical Information

ICD9 Code:

555.0 Regional Enteritis (small intestine) 555.1 Regional Enteritis (large intestine)

555.2 Regional Enteritis (small w/large intestine) 555.9 Regional Enteritis (unspecified site)

Other (include code) _____

Treatments: Prior Current

Biologics Orals Other: _____

Additional medical rationale for treatment: (complete or attach medical history)

No response to previous treatment: (list) _____

Contraindications to other treatments: (list) _____

Side effects, lab abnormalities, toxicity issues with other treatments: (list) _____

Other: _____

Prescription Information

Cimzia® (certolizumab pegol)

Initial Dose:

400 mg SC at week 0, 2, and 4 followed by:

Maintenance Dose: (If response occurs)

400mg SC every 4 weeks

Other: _____

Humira® (adalimumab)

Initial Dose:

Inject 160mg SC on day 1, 80mg on day 15, then 40mg every other week

Maintenance Dose:

Inject 40mg SC every other week

40mg/0.8ml, PEN (2 pens/box) 40mg/0.8ml, PFS (2 pfs/box)

Remicade® (infliximab)

Infuse Remicade in NS 250ml over 2 hours as directed

5mg/kg IV at 0, 2, and 6 weeks

Maintenance Dose:

5mg/kg IV every 8 weeks

Dispense:

Quantity _____ Refill _____ times

Need Supplies: Please specify _____

Ancillary supplies/kits provided as needed for administration.