Optum

Optum specialty phone: 855-427-4682
Optum specialty fax: 877-342-4596

Gastroenterology Enrollment Form

Specialty pharmacy enrollment form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona and Virginia**

Patient information

*Please complete the following or **send patient demographic sheet***

Patient name _____
Address _____
Address 2 _____
City, State, Zip _____
Home phone _____ Alternate phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber information

Prescriber's name _____
DEA _____
NPI _____
Group/ Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact person _____ Phone _____
(Must fax a copy of patient's insurance card including both sides)

Medical information *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications
☐ Other diagnosis: ICD-10 Code ___ Description _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start date _____ **Review date** _____

Additional information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____kg/lbs Height _____cm/in
Allergies _____
Lab data _____
Prior therapies _____
Injection training required: ☐ Yes ☐ No

Prescription information

Medication	Strength	Dose & Directions	Qty	Refills
☐ Abrilada™ (adalimumab-afzb)	☐ 20 mg/0.4 mL prefilled syringe ☐ 40 mg/0.8 mL prefilled syringe ☐ 40 mg/0.8 mL pen	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29) Pediatric Crohn's disease (≥ 6 years and adolescents): **17 kg to <40 kg** ☐ Initiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29)		
☐ Amjevita™ (adalimumab-atto)	☐ 20 mg/0.4 mL Prefilled syringe (citrate-free) ☐ 40 mg/0.8 mL Prefilled syringe (citrate-free) ☐ 40 mg/0.8 mL Prefilled SureClick® autoinjector (citrate-free)	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29) Pediatric (≥ 6 years and adolescents): **17 kg to <40 kg** ☐ Initiation: Inject 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29)		
☐ Avsola® (infliximab-axxq)	☐ 100 mg vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Cimzia® (certolizumab pegol)	☐ 200 mg/ mL Vial kit ☐ 200 mg/ mL Starter kit ☐ 200 mg/ mL Prefilled syringe	☐ Initiation - Inject 400 mg SQ at Weeks 0, 2, and 4 ☐ Maintenance - Inject 400 mg SQ every 4 weeks		

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other_____ Date:_____ Needs by date:_____

Dispense as Written	**Substitution Permitted**
Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.	Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.
Supervising/Collaborative Physician Information (per state requirements) _____	

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Specialty pharmacy enrollment form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona and Virginia**

Patient information

Please complete the following or ***send patient demographic sheet***

Patient name _____
Address _____
Address 2 _____
City, State, Zip _____
Home phone _____ Alternate phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber information

Prescriber's name _____
DEA _____
NPI _____
Group/ Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact person _____ Phone _____
(Must fax a copy of patient's insurance card including both sides)

Medical information *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications
☐ Other diagnosis: ICD-10 Code ___ Description _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start date _____ **Review date** _____

Additional information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____kg/lbs Height _____cm/in
Allergies _____
Lab data _____
Prior therapies _____
Injection training required: ☐ Yes ☐ No

Prescription information

Medication	Strength	Dose & Directions	Qty	Refills
☐ Cyltezo® (adalimumab-adbm)	Starter Kits: ☐ 40 mg/0.4mL Pen Start Pack Crohn's Disease/ Ulcerative Colitis (6 pens) ☐ 40 mg/0.8mL Pen Start Pack Crohn's Disease/ Ulcerative Colitis (6 pens) Maintenance: ☐ 40 mg/0.4mL Pen ☐ 40 mg/0.4mL prefilled syringe ☐ 40 mg/0.8mL Pen ☐ 40 mg/0.8mL prefilled syringe	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29) Pediatric Crohn's disease (≥6 years and adolescents): **17 kg to <40 kg** ☐ Initiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting on Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29)		
☐ Dupixent® (dupilumab)	☐ 300 mg/2ml Prefilled Pen ☐ 300 mg/2ml Prefilled Syringe	☐ Inject 300 mg SQ every week ☐ Other:_____		
☐ Entyvio® (vendolizumab)	☐ 300 mg vial	☐ Initiation - Infuse 300 mg IV over 30 minutes at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 300 mg IV over 30 minutes every 8 weeks		
☐ Entyvio® (vendolizumab)	☐ 108 mg/0.68mL prefilled syringe ☐ 108 mg/0.68mL prefilled pen	☐ Dates of initial infusions:_____ ☐ Maintenance - Inject 108 mg SQ every 2 weeks		
☐ Hadlima™ (adalimumab-bwwd)	☐ 40mg/0.4ml prefilled syringe ☐ 40mg/0.8ml prefilled syringe ☐ 40mg/0.4ml PushTouch auto-injector ☐ 40mg/0.8ml PushTouch auto-injector	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29) Pediatric Crohn's disease (≥6 years and adolescents): **17 kg to <40 kg** ☐ Initiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting on Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29)		

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other_____ Date:_____ Needs by date:_____

Dispense as Written	**Substitution Permitted**
Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.	Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.
Supervising/Collaborative Physician Information (per state requirements) _____	

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Gastroenterology Enrollment Form

Specialty pharmacy enrollment form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona and Virginia**

Patient information

*Please complete the following or **send patient demographic sheet***

Patient name _____
Address _____
Address 2 _____
City, State, Zip _____
Home phone _____ Alternate phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber information

Prescriber's name _____
DEA _____
NPI _____
Group/ Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact person _____ Phone _____
(Must fax a copy of patient's insurance card including both sides)

Medical information *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications
☐ Other diagnosis: ICD-10 Code ___ Description _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start date _____ **Review date** _____

Additional information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____kg/lbs Height _____cm/in
Allergies _____
Lab data _____
Prior therapies _____
Injection training required: ☐ Yes ☐ No

Prescription information

Medication	Strength	Dose & Directions	Qty	Refills
☐ Hulio® (adalimumab-fkjp)	☐ 20 mg/0.4mL prefilled syringe ☐ 40 mg/0.8mL prefilled syringe ☐ 40 mg/0.8mL pen	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29) Pediatric Crohn's disease (≥6 years and adolescents): **17 kg to <40 kg** ☐ Initiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting on Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29)		
☐ Humira® (adalimumab)	Starter kits: ☐ 80 mg/0.8mL Starter pack pre-filled pen (citrate free) Maintenance: ☐ 40 mg/0.4mL Pre-filled pen (citrate free) ☐ 40 mg/0.4mL Pre-filled syringe (citrate free) ☐ 40 mg/0.8mL Pre-filled pen kit ☐ 40 mg/0.8mL Pre-filled syringe kit Other:_____	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29) Pediatric (≥ 6 years and adolescents): **17 kg to <40 kg** ☐ Initiation: Inject 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (starting Day 29)		

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other_____ Date:_____ Needs by date:_____

Dispense as Written	**Substitution Permitted**
Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.	Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.
Supervising/Collaborative Physician Information (per state requirements) _____	

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Gastroenterology Enrollment Form

Specialty pharmacy enrollment form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona and Virginia**

Patient information

*Please complete the following or **send patient demographic sheet***

Patient name _____
Address _____
Address 2 _____
City, State, Zip _____
Home phone _____ Alternate phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber information

Prescriber's name _____
DEA _____
NPI _____
Group/ Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact person _____ Phone _____
(Must fax a copy of patient's insurance card including both sides)

Medical information *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications
☐ Other diagnosis: ICD-10 Code ___ Description _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start date _____ **Review date** _____

Additional information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____kg/lbs Height _____cm/in
Allergies _____
Lab data _____
Prior therapies _____
Injection training required: ☐ Yes ☐ No

Prescription information

Medication	Strength	Dose & Directions	Qty	Refills
☐ Hyrimoz® (adalimumab-adaz)	Starter Kit: ☐ 80 mg/0.8ml Sensoready Pen Crohn's Disease/Ulcerative Colitis starter pack ☐ 80 mg/0.8mL prefilled syringe Pediatric Crohn's starter pack ☐ 80 mg/0.8mL + 40 mg/0.4mL prefilled syringe pediatric Crohn's starter pack Maintenance: ☐ 10 mg/0.1mL prefilled syringe ☐ 20 mg/0.2mL prefilled syringe ☐ 40 mg/0.4mL prefilled syringe ☐ 40 mg/0.8mL prefilled syringe ☐ 40 mg/0.4mL auto-injector ☐ 80 mg/0.8mL auto-injector	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29) Pediatric Crohn's disease (≥6 years and adolescents): **17 kg to <40 kg** ☐ Initiation: 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 20 mg SQ every other week (starting on Day 29) **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29)		
☐ Idacio® (adalimumab-aacf)	Starter Kit: ☐ 40 mg/0.8ml Crohn's disease/ulcerative colitis Start Kit Maintenance: ☐ 40 mg/0.8ml auto-injector ☐ 40 mg/0.8ml prefilled syringe	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29) Pediatric Crohn's disease (≥6 years and adolescents): **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29)		
☐ Inflectra® (infliximab-dyyb)	☐ 100 mg vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Omvoh® (mirikizumab-mrkz)	☐ 300 mg vial (for IV infusion) ☐ 100 mg/1mL prefilled pen Date of initial infusion: _____	☐ Induction Dosing: Give 300 mg via IV infusion over at least 30 minutes at week 0, week 4, and week 8 ☐ Maintenance Dosing: Inject 200mg (2 injections) subcutaneously at week 12 and every 4 weeks		
☐ Remicade® (infliximab)	☐ 100 mg vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other_____ Date:_____ Needs by date:_____

Dispense as Written	**Substitution Permitted**
Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.	Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.
Supervising/Collaborative Physician Information (per state requirements) _____	

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Specialty pharmacy enrollment form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona and Virginia**

Patient information

*Please complete the following or **send patient demographic sheet***

Patient name _____
Address _____
Address 2 _____
City, State, Zip _____
Home phone _____ Alternate phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber information

Prescriber's name _____
DEA _____
NPI _____
Group/ Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact person _____ Phone _____
(Must fax a copy of patient's insurance card including both sides)

Medical information *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications
☐ Other diagnosis: ICD-10 Code ___ Description _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start date _____ **Review date** _____

Additional information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____kg/lbs Height _____cm/in
Allergies _____
Lab data _____
Prior therapies _____
Injection training required: ☐ Yes ☐ No

Prescription information

Medication	Strength	Dose & Directions	Qty	Refills
☐ Renflexis® (infliximab-abda)	☐ 100 mg vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
☐ Rinvoq® (upadacitinib)	☐ 45 mg tablet-Loading dose ☐ 15 mg tablet-Maintenance dose ☐ 30 mg tablet-Maintenance dose	☐ Crohn's disease induction: Take 45 mg PO once daily for 12 weeks ☐ Ulcerative colitis induction: Take 45 mg PO once daily for 8 weeks ☐ Maintenance dose: Take 15 mg PO once daily ☐ Alternative maintenance dose: Take 30 mg PO once daily		
☐ Simlandi® (adalimumab-ryvk)	☐ 40 mg/0.4 mL auto-injector	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29) Pediatric Crohn's disease (≥6 years and adolescents): **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29)		
☐ Simponi® (golimumab)	☐ 100 mg/mL SmartJect autoinjector ☐ 100 mg/mL Prefilled syringe	☐ Initiation - Inject 200 mg SQ at Week 0 then 100 mg at Week 2 ☐ Maintenance - Inject 100 mg SQ every 4 weeks		
☐ Skyrizi® (Risankizumab-rzaa)	☐ 600 mg/10 mL single-dose vial-initiation dose ☐ 360 mg/2.4 mL single-dose prefilled cartridge with On-body injector-maintenance dose ☐ 180 mg/1.2 mL single-dose prefilled cartridge with On-body injector-maintenance dose Date of initial infusion: _____	☐ Adult Crohn's disease (CD) Induction: Infuse 600 mg IV over ≥1 hour at Week 0, 4, and 8 ☐ Adult Ulcerative Colitis (UC) Induction: Infuse 1200 mg IV over ≥ 2 hours at Week 0, 4, and 8 Maintenance dose: ☐ 360 mg by SQ injection at week 12, and every 8 weeks thereafter ☐ 180 mg by SQ injection at week 12, and every 8 weeks thereafter		
☐ Stelara® (ustekinumab)	☐ 130 mg/26 mL solution single dose vial ☐ 90 mg/mL Prefilled syringe Date of initial infusion: _____	☐ Initiation - Infuse: ☐ 260 mg ☐ 390 mg ☐ 520 mg as initial IV dose as directed by prescriber ☐ Maintenance - Inject 90 mg SQ every 8 weeks (begin dosing 8 weeks after the IV induction dose)		

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other_____ Date:_____ Needs by date:_____

Dispense as Written	**Substitution Permitted**
Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.	Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.
Supervising/Collaborative Physician Information (per state requirements) _____	

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Specialty pharmacy enrollment form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona and Virginia**

Patient information

Please complete the following or ***send patient demographic sheet***

Patient name _____
Address _____
Address 2 _____
City, State, Zip _____
Home phone _____ Alternate phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber information

Prescriber's name _____
DEA _____
NPI _____
Group/ Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact person _____ Phone _____
(Must fax a copy of patient's insurance card including both sides)

Medical information *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications
☐ Other diagnosis: ICD-10 Code ___ Description _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start date _____ **Review date** _____

Additional information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____kg/lbs Height _____cm/in
Allergies _____
Lab data _____
Prior therapies _____
Injection training required: ☐ Yes ☐ No

Prescription information

Medication	Strength	Dose & Directions	Qty	Refills
☐ Tremfya® (guselkinumab)	☐ 10 mg/mL IV solution ☐ 200 mg/2 mL Pen ☐ 200 mg/2 mL prefilled syringe ☐ Date of initial infusion: _____	☐ Ulcerative colitis induction: Infuse 200mg IV infusion over ≥ 1 hour at week 0, week 4, and week 8 Maintenance: ☐ Inject 100mg subQ at week 16 and then every 8 weeks ☐ Inject 200mg subQ at week 12 and then every 4 weeks		
☐ Velsipity® (etrasimod)	☐ 2 mg tablet	☐ Take 1 tablet by mouth once daily		
☐ Xeljanz® (tofacitinib)	☐ 5 mg tablet ☐ 10 mg tablet ☐ 11 mg XR tablet ☐ 22 mg XR tablet	☐ Initiation: ☐ 10 mg twice daily for 8 weeks ☐ XR: 22 mg once daily for 8 weeks ☐ Maintenance: _____ ☐ 5 mg twice daily ☐ XR: 11 mg once daily ☐ 10 mg twice daily ☐ XR: 22 mg once daily		
☐ Yusimry® (adalimumab-aqvh)	☐ 40 mg/0.4mL prefilled syringe ☐ 40 mg/0.4mL auto-injector	Adult: ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29) Pediatric Crohn's disease (≥6 years and adolescents): **≥40 kg** ☐ Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) ☐ Maintenance: Inject 40 mg SQ every other week (Starting on Day 29)		
☐ Zeposia® (ozanimod)	☐ 0.92 mg capsule ☐ 7-Day starter pack ☐ 37 Day starter kit (starter pack + 0.92 mg capsules)	☐ Initiation: Take 0.23 mg once daily for days 1-4, then take 0.46 mg once daily for days 5-7, then take 0.92 mg once daily on day 8 and every day thereafter ☐ Maintenance: Take 0.92 mg once daily		
☐ Zymfentra™ (infliximab-dyyb)	☐ 120 mg/mL auto-injector ☐ 120 mg/mL prefilled syringe	**Prior to initiation,** an IV induction regimen with an infliximab product must be completed prior to starting subcutaneous therapy. ☐ Maintenance: Inject 120mg subcutaneously every 2 weeks starting at week 10		

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other_____ Date:_____ Needs by date:_____

Dispense as Written	**Substitution Permitted**
Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.	Prescriber's Signature_____ Date _____ Electronic or digital signatures not accepted.
Supervising/Collaborative Physician Information (per state requirements) _____	

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.