

# **Gastroenterology Enrollment Form**

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Specialty pharmacy en	rollment form Rease detach before submi	tting to a pharmacy - tear here. This form is not a valid prescription in	Arizona aı	nd Virginia
Patient information		Prescriber information		
Please complete the following or send patient demographic sheet  Patient name		Prescriber's name		
Medical inforn	nation (Section must be completed to p	process prescription) (Attach separate sheet if needed)		
<b>Diagnosis –</b> Please i	nclude diagnosis name with ICD-10 code	Additional information Therapy: ☐ New ☐ Reauthorization	ı 🗌 Resta	art
<ul> <li>         □ 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         □ Yes □ No</li></ul>		Weightkg/lbs Heightcm/in Allergies Lab data Prior therapies Injection training required:		
Prescription in	formation			
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 <sup>®</sup> (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: Product substitution permitted Dispense as written  Prescriber's Supervising Signature Date Date Physician Signature: Date  Electronic or digital signatures not accepted.				

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Patient inform	nation	Prescriber in	formation	
Patient name	Alternate phone Alternate phone Second Four of SS# Gender Ce: English Spanish Other Characteristics of small intestine without complications sease of small intestine without complications sease, unspecified, without complications (CD-10 Code Description Cerformed? Yes No	DEA	FaxPhone atient's insurance card including both sides)	on
	ve an active infection?	Injection training	required:   res   NO	
Prescription in  Cyltezo* (adalimumab-adbm)		Maintenance: Inject ← Pediatric Crohn's disease  17 kg to <40 kg  Initiation: 80 mg SQ ← Maintenance: Inject 2 ≥40 kg  Initiation: Inject 160	mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) 40 mg SQ every other week (Starting on Day 29) e (26 years and adolescents): on Day 1, 40 mg on Day 15 (two weeks later) 0 mg SQ every other week (starting on Day 29) mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) 40 mg SQ every other week (Starting on Day 29) week	
Entyvio° (vendolizumab)	☐ 300 mg vial		omg IV over 30 minutes at Weeks 0, 2, and 6 300 mg IV over 30 minutes every 8 weeks	
☐ Entyvio° (vendolizumab) ☐ Hadlima™	108 mg/0.68mL prefilled syringe 108 mg/0.68mL prefilled pen	Dates of initial infusion		
(adalimumab-bwwd)	□ 40mg/0.4ml prefilled syringe     □ 40mg/0.8ml prefilled syringe     □ 40mg/0.4ml PushTouch auto-injector     □ 40mg/0.8ml PushTouch auto-injector	☐ Initiation: Inject 160 I ☐ Maintenance: Inject 4 Pediatric Crohn's disease 17 kg to <40 kg ☐ Initiation: 80 mg SQ I ☐ Maintenance: Inject 2 ≥40 kg ☐ Initiation: Inject 160 I ☐ Maintenance: Inject 4	mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) 40 mg SQ every other week (Starting on Day 29) e (26 years and adolescents): on Day 1, 40 mg on Day 15 (two weeks later) 20 mg SQ every other week (starting on Day 29) mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) 40 mg SQ every other week (Starting on Day 29)	
coverage and initiate the necessity, on my behalthat support the prior a information and any reship to:	Date	act as my authorized age atient, and to sign any ne thorization forms and th s that it is unable to fulfi other pharmacy of the pa Date: Supervising	ent, where permitted by law and benefit plan spo ecessary forms, including but not limited to, atte e receipt and submission of patient lab values ar Il this prescription, I further authorize this pharm atient's choice or in the patient's insurer's provid	stations of medical ad other patient data nacy to forward this

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Patient inform	nation	Prescriber information	
Patient name	Alternate phone Four of SS# Gender Ce: Denglish Denglish Other	Prescriber's name	
	-	process prescription) (Attach separate sheet if needed)  Additional information Therapy:  New Reauthorization	n □ Restart
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		Weightkg/lbs Height Allergies Lab data Prior therapies Injection training required:  \[ \text{Yes} \] No	cm/in
Prescription in	formation		
∏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:  \$\textbf{80 mg/0.8mL Starter pack pre-filled pen}\$ (citrate free)\$ Maintenance:  \$\textbf{40 mg/0.4mL Pre-filled pen (citrate free)}\$ 40 mg/0.4mL Pre-filled syringe (citrate free)\$ 0 mg/0.8mL Pre-filled pen kit\$ 0 mg/0.8mL Pre-filled syringe kit\$ 0 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 (2 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)   240 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)	
∏ 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/0.4mL prefilled syringe   40 mg/0.8mL prefilled syringe   40 mg/0.8mL 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 (26 years and adolescents):   17 kg to 440 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)   240 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)	
coverage and initiate t necessity, on my behal that support the prior information and any re Ship to:	he insurance prior authorization process for our shared p f as my authorized agent, including any required prior aut authorization. In the event that this pharmacy determine	act as my authorized agent, where permitted by law and benefit plan spor atient, and to sign any necessary forms, including but not limited to, attest chorization forms and the receipt and submission of patient lab values and s that it is unable to fulfill this prescription, I further authorize this pharma other pharmacy of the patient's choice or in the patient's insurer's provider Date:	ations of medical other patient data cy to forward this
Product substitution Prescriber's Signature  Flectropic or digital signatures	on permitted Dispense as written  Date	Supervising	ıte

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Patient information		Prescriber information	
Patient name	Alternate phone Gender Cee: English Spanish Other	Prescriber's name  DEA	
		process prescription) (Attach separate sheet if needed)	
☐ K50.00 Crohn's di ☐ K50.10 Crohn's di ☐ K50.90 Crohn's d ☐ Other diagnosis: Has a TB test been p Does the patient ha	include diagnosis name with ICD-10 code  isease of small intestine without complications sease of large intestine without complications isease, unspecified, without complications ICD-10 Code Description performed? Yes No	Additional information Therapy:  New Reauthori  Weight kg/lbs Height Allergies Lab data Prior therapies Injection training required: Yes No	cm/in
Prescription in	nformation		
☐ 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 lated the model of the model	
☐ 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 wee and every 4 weeks	
Remicade <sup>®</sup> (infliximab)	□100 mg vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks	
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 <sup>®</sup> (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	
Simponi <sup>*</sup> (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:	□ Initiation-Infuse 600 mg as initial IV dose at Week 0, Week 4, and Week 8 as directed by prescriber 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	
coverage and initiate t necessity, on my behal that support the prior	he insurance prior authorization process for our shared p f as my authorized agent, including any required prior aut authorization. In the event that this pharmacy determine	act as my authorized agent, where permitted by law and benefit plan atient, and to sign any necessary forms, including but not limited to, thorization forms and the receipt and submission of patient lab value s that it is unable to fulfill this prescription, I further authorize this prother pharmacy of the patient's choice or in the patient's insurer's prother pharmacy of the patient's choice or in the patient's insurer's prother patient labels.	attestations of medical es and other patient data parmacy to forward this
Patient Office-	first fill only Office-all fills Other	Date: Needs by date:	
Product substitution Prescriber's Signature Flectropic or digital signatures	Date	Supervising Physician Signature:	Date

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Patient inform	ation	Prescriber information	
Patient name Address Address 2 City, State, Zip Home phone DOB Last	following or send patient demographic sheet  Alternate phone  Four of SS# Gender  ce: English Spanish Other	Prescriber's name	
Medical inform	nation (Section must be completed to	process prescription) (Attach separate sheet if needed)	
	nclude diagnosis name with ICD-10 code	Additional information Therapy:   New  Reauthorizati	on 🗌 Restart
	isease of small intestine without complications sease of large intestine without complications sease, unspecified, without complications in its complex in its com	Weightkg/lbs Height Allergies Lab data Prior therapies Injection training required:	
Prescription in	formation		
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)	
☐ Velsipity (etrasimod)	☐2 mg tablet	☐ Take 1 tablet by mouth once daily	
∏Xeljanz* (tofacitinib)	□ 5 mg tablet □ 10 mg tablet □ 11 mg XR tablet □ 12 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 (26 years and adolescents):   240 kg	
∏Yusimry™ (adalimumab-aqvh)	☐ 40 mg/0.8mL prefilled syringe ☐ 40 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 (26 years and adolescents):   240 kg	
□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	
coverage and initiate the necessity, on my behalf that support the prior a information and any resolution.	he insurance prior authorization process for our shared process for	act as my authorized agent, where permitted by law and benefit plan sponatient, and to sign any necessary forms, including but not limited to, atteithorization forms and the receipt and submission of patient lab values ares that it is unable to fulfill this prescription, I further authorize this pharm other pharmacy of the patient's choice or in the patient's insurer's provid  Date: Needs by date:  Supervising Physician Signature: [	stations of medical nd other patient data nacy to forward this

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