

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

Crohn's/Ulcerative Colitis enrollment form

Image: State in the state without complications Allergies Image: State in the state infection? Image: State infection? Image: State infection? Image: State	Specialty pharmacy en	rollment form 😽 Please detach before	submitting to a pharmacy - tear here. This form is not a valid pre	scription in Arizona
Patter in anne DEA Address Croue / Hong Index Home phone Fax Home phone Fax Laguage preference English English Section must be complected to precises prescription / times acced netwing boateab Medical Information Therapy Result Confination (Section must be complection) Additional information Result Confination (Section (Strength) Additional information Description information Description Result Section (Confination) Description (Section (Secti	Patient inforn	nation	Prescriber information	
Dees the patient have an active infection? Yes No Arrigevita* Review ade	Patient name Address Address 2 City, State, Zip Home phone DOB Las Language preferen Medical inforr Diagnosis – <i>Please</i> G K50.00 Crohn's d G K50.10 Crohn's d G K50.90 Crohn's d	Alternate phone	DEA	cm/in
Medication Dose/Strength Directions Oty Refil _Anjexita"	Does the patient ha	ave an active infection? 🛛 Yes 🗌 No	Injection training required: Yes No	
Medication Dose/Strength Directions Oty Refil Anjevita" 0 mg/0 & mL. Prefilled syrings (clitate-free) 1 mitation. Inject 160 mg SQ on Day L then 80 mg on Day 15 0 mg/0 & mL. Prefilled SureClick" Adult: 1 mitation. Inject 160 mg SQ on Day L then 80 mg on Day 15 0 mg/0 & mL. Prefilled SureClick" 1 mitation. Inject 160 mg SQ on Day 1.40 mg on Day 15 0 mg/0 & mL. Prefilled SureClick" 1 mitation. Inject 160 mg SQ on Day 1.40 mg on Day 15 0 mg/0 mL. Vial Kit 1 mitation. Inject 40 mg SQ every other week (starting Day 29) 0 mg/0 mL. Vial Kit 0 mg/0 mg/0 mL. Vial Kit 1 mitation. Inject 40 mg SQ every other week (starting Day 29) 0 mg/0 mL. Vial Kit 0 mg/0 mL. Vial Kit <	Prescription i	nformation		
Image: Second		· ·		Qty Refills
Cimzia' 200 mg/mL Vial kit 200 mg/mL Starter kit Initiation - Inject 400 mg SQ at Weeks 0, 2, and 4 Humira' Maintenance - Inject 400 mg SQ every 4 weeks Humira' B0 mg/0.8mL Starter pack pre-filled pen (citrate free) Aduit: Humira' B0 mg/0.8mL Crohns disease starter package prefilled syringe Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) Humira' Gim g/0.8mL Crohns disease starter package prefilled syringe Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) Humira' Humira' Initiation: Longet 160 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) Humira' Humira' Initiation: Inject 20 mg SQ every other week (starting Day 29) Pediatric (c S years and adolescents): If y to <40 kg		☐ 40 mg/0.8 mL Prefilled syringe (citrate-free) ☐ 40 mg/0.8 mL Prefilled SureClick®	 ☐ 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) 	
Humira* Starter kits: Adult: B0 mg/0.8mL Starter pack pre-filled pen (citrate free) Initiation: Inject 160 mg SQ on Day 1, then 80 mg on Day 15 (two weeks later) A0 mg/0.8mL Crohns disease starter package prefilled syringe Maintenance: Inject 40 mg SQ or Day 1, 40 mg on Day 15 (two weeks later) A0 mg/0.8mL Crohns disease starter package prefilled syringe Initiation: Inject 80 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) A0 mg/0.8mL Pre-filled pen (citrate free) Maintenance: Inject 40 mg SQ or Day 1, 40 mg on Day 15 (two weeks later) A0 mg/0.8mL Pre-filled pen kit Initiation: Inject 160 mg SQ on Day 1, 40 mg on Day 15 (two weeks later) A0 mg/0.8mL Pre-filled pen kit Initiation: Inject 160 mg SQ or Day 1, 40 mg on Day 15 (two weeks later) A0 mg/0.8mL Pre-filled pen kit Initiation: Inject 160 mg SQ or Day 1, 40 mg on Day 15 (two weeks later) A1 mintenance: Inject 40 mg SQ every other week (starting Day 29) 240 kg Initiation: Take 45 mg PO once daily A1 mintenance: Inject 40 mg SQ every other week (starting Day 29) I Simponi* 100 mg/m. Prefilled syringe I Dio mg/m. Prefilled syringe Maintenance: Inject 200 mg SQ every other weeks *Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patientla's values and oth	Cimzia°			
Image: Simponi Image	☐ Humira°	Starter kits: 80 mg/0.8mL Starter pack pre-filled pen (citrate free) 40 mg/0.8mL Crohns disease starter package prefilled syringe 40 mg/0.8mL Crohns disease starter package pre-filled pen 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 syringe kit	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	
Control in the patient is prevented by the patient of the patient's choice or in the patient's ch	🗌 Rinvoq	15 mg tablet-Maintenance dose	Maintenance dose: Take 15 mg PO once daily	
process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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	Simponi [®]		☐ Initiation - Inject 200 mg SQ at Week 0 then 100 mg at Week 2	
Prescriber's Supervising Date Date Date Date Date	process for my patient receipt and submissio this pharmacy to forw insurer's provider netw Ship to:	t(s), and to sign any necessary forms on my behalf as my a n of patient lab values and other patient data. In the even ard this information and any related materials related to c vork. -first fill onlyOffice-all fillsOther	authorized agent, including the receipt of any required prior authorization t that this pharmacy determines that it is unable to fulfill this prescriptior overage of the product to another pharmacy of the patient's choice or in	n forms and the n, I further authorize
Signature Date Date Physician Signature: Date Date				
Electronic or digital signatures not acconted	Signature		Physician Signature: D	ate
Electronic or digital signatures not accepted. 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,				

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.



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Specialty pharmacy enr	rollment form 🖗 Please detach before s	submitting to a pharmacy - tear here. This form is not a valid pres	scription in	Arizona
Patient inform	nation	Prescriber information		
Please complete the following or send patient demographic sheet Patient name Address		Prescriber's name DEA NPI		
Address 2		Group/Hospital		
City, State, Zip		Address City, State, ZIP		
Home phone	Alternate phone	Phone Fax		
	Four of SS# Gender	Contact person Phone		
	ce: _ English _ Spanish _ Other	(Must fax a copy of patient's insurance card including both sides)		
		rocess prescription) (Attach separate sheet if needed)		
_	nclude diagnosis name with ICD-10 code	Additional information Therapy: 🗌 New 🗌 Reauthorizatio		0
☐ K50.00 Crohn's disease of small intestine without complications		Weightkg/lbs Height		cm/in
	sease of large intestine without complications	Allergies		
	isease, unspecified, without complications	Lab data		
	ICD-10 Code Description performed? □ Yes □ No	Prior therapies		
	ve an active infection?	Injection training required: 🗌 Yes 🗌 No		
	Review date			
Prescription ir				
Medication	Dose/Strength	Directions	Qty	Refills
🗌 Skyrizi	600 mg/10 mL single-dose vial-initiation dose 360 mg/2.4 mL single-dose prefilled cartridge with On-body injector-maintenance dose	☐ Initiation-Infuse 600 mg as initial IV dose at Week 0, Week 4, and Week 8 as directed by prescriber Maintenance dose:		
	☐ 180 mg/1.2 mL single-dose prefilled cartridge with On-body injector-maintenance dose Date of initial infusion:	\square 360 mg by SQ injection at week 12, and every 8 weeks thereafter \square 180 mg by SQ injection at week 12, and every 8 weeks thereafter		
☐ Stelara°	☐ 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) 		
∏Xeljanz	☐ 5 mg tablet ☐ 10 mg tablet ☐ 11 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		
	22 mg XR tablet	☐ 10 mg twice daily ☐ XR: 22 mg once daily		
∏Zeposia	☐ 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 		
Entyvio°	🗌 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 		
☐ Inflectra®	☐100 mg vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
🗌 Remicade°	☐100 mg vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
Renflexis®	☐100 mg vial	 Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 Maintenance - Infuse 5 mg/kg every 8 weeks 		
Avsola®	☐100 mg vial	☐ Initiation - Infuse 5 mg/kg at Weeks 0, 2, and 6 ☐ Maintenance - Infuse 5 mg/kg every 8 weeks		
process for my patient receipt and submission this pharmacy to forwa insurer's provider netw Ship to:	(s), and to sign any necessary forms on my behalf as my au n of patient lab values and other patient data. In the event and this information and any related materials related to co ork.	ict as my authorized agent to secure coverage and initiate the insurance p uthorized agent, including the receipt of any required prior authorization is that this pharmacy determines that it is unable to fulfill this prescription, overage of the product to another pharmacy of the patient's choice or in t Date: Needs by date:	forms and t . I further au	he uthorize
Prescriber's Signature	Data	Supervising Physician Signature: Da	ate	
Signature Electronic or digital signatures r	Date	Da	ite	
Confidentiality statem confidential, and exem delivery of the commu	ent: This communication is intended for the use of the ind pt from disclosure under applicable law. If the reader of th	lividual or entity to which it is addressed and may contain information tha nis communication is not the intended recipient or the employee or agen listribution, or copying of the communication is strictly prohibited. If you not a valid prescription in Arizona.	t responsibl	le for