Optum

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

Crohn's / Ulcerative Colitis enrollment form

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

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	Dose / Strength	Directions	Qty	Refills
☐ Amjevita™	☐ 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)		
☐ Cimzia®	☐ 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		
☐ 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 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)		
☐ Rinvoq	☐ 45 mg tablet-Loading dose ☐ 15 mg tablet-Maintenance dose ☐ 30 mg tablet-Maintenance dose	☐ Initiation: 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®	☐ 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		

***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 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 Signature _____ Date _____

Supervising Physician Signature: _____ Date _____

Electronic or digital signatures not accepted.

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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	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 ☐ 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		
☐ 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 ☐ 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		
☐ 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		

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☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature _____ Date _____

Supervising Physician Signature: _____ Date _____

Electronic or digital signatures not accepted.