CompreCare | Rx

Specialty Pharmacy
JCAHO Accredited

CROHN´S ENROLLMENT FORM

Phone: 800-541-2030
Fax: 888-862-4769

PATIENT INFORMATION

Patient Name	Male ☐ Female ☐	Allergies NKDA
Date of Birth	SSN#	Weight Kg Lb Date / /
Address	City	State/Zip
Phone # (Home)	Work #	Email Address
Caregiver	Case Manager	

INSURANCE INFORMATION

Primary Insurance	Policy Holder
Group # Policy #	Phone #
Secondary Insurance Policy #	Phone #

DIAGNOSIS/MEDICAL INFORMATION (PLEASE SPECIFY PRIMARY & SECONDARY DIAGNOSIS)

☐ K50.90 Crohn's Disease NOS ☐ K50.0 Crohn's small intestine ☐ K50.1 Crohn's large intestine

☐ Other ICD-10 Severity Type: ☐ Mild ☐ Moderate ☐ Severe ☐ Fistulizing

Does the patient have CHF (NYHA Class III/IV)? ☐ Yes ☐ No ☐ Induction therapy ☐ Maintenance therapy

Does patient have clinically important active infection? ☐ Yes ☐ No

TB skin test result ☐ Negative ☐ Positive Date: / /

Failure of (check all that apply & list dosing/therapy below):

☐ Mesalamine ☐ Corticosteroids ☐ Mercaptaopurine ☐ Azathioprine ☐ Sulfasalazine ☐ Methotrexate

☐ Other ☐ None

Is patient new to therapy? ☐ Yes ☐ No If no, date therapy began / / Date of Diagnosis: / /

PREVIOUS MEDICATIONS (PLEASE SPECIFY DOSAGE & TIME ON THERAPY)

Medication Strength & Dose	Dates of Therapy	Reason for Discontinuing

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Refills
☐ Cimzia®	☐ 200 mg/1ml. Prefilled Syringe ☐ 200 mg vial	☐ Induction Dose. Inject SubQ 400 mg (2 vials) on day 1, and at weeks 2 and 4 ☐ Maintenance Dose. Inject SubQ 400 mg (2 vials) every 4 weeks	3 kits (6 vials)	
☐ Humira PFS® ☐ Humira Pen®	☐ 40 mg	☐ SubQ every other week ☐ _____		
☐ Remicade® (infliximab)	☐ 5 mg/kg ☐ ____ mg/kg	☐ IV @ 0, 2, & 6 weeks (induction) ☐ IV every 6 weeks (maintenance for AS)/(maintenance for PsA) ☐ IV every ____weeks (Must be dispensed to physician's office or infusion center)		
☐ Simponi PFS® ☐ Simponi Pen®	☐ 50 mg ☐ 100 mg	☐ Induction Dose. 200 mg (2 x 100 mg) SubQ on Week 0 then 100 mg SubQ at 2 weeks end ☐ Maintenance Dose. 100 mg SubQ every 4 weeks	3 Syringes 1 Syringe	
☐ Tysabri®				

DELIVERY INSTRUCTIONS

☐ Physician's Office ☐ Patient's Home ☐ Other

Address Phone #

City/State/Zip Date Medication Needed / /

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Phone Fax
Address	City/State/Zip
NPI # DEA #	Office Contact

Physician Signature Date
(signature required to process prescription)