DOTTIE'S PHARMACY
specialty & compounding

Crohn's / Ulcerative Colitis Medications Enrollment Form

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Charleston, SC 29412
PH: (843) 501-9500
FAX: (843) 414-7453

Date: _____ Needs by date: _____ Ship to: Patient ____ Office: ____ Other: _____

Patient Information:

Patient Name: _____
Address: _____
City, State, Zip: _____
Main Phone: _____ Alt. Phone: _____
Last 4 of SSN: _____ Height _____ ○ in ○ cm Weight _____ ○ lbs ○ kg
Date of Birth: _____ ○ Male ○ Female

Prescriber Information:

Prescriber Name: _____
DEA: _____ NPI: _____ Group: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact Person: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF PRESCRIPTION CARD AND MEDICAL CARD (FRONT AND BACK)

Clinical Information: Statement of Medical Necessity

Primary Diagnosis: _____ Date of Diagnosis/ Years with Disease: _____ Allergies: _____ ○ NKDA

ICD -10 code: ○ K50.90 Crohn's Unspecified ○ K50.00 Crohn's small intestine ○ K50.10 Crohn's large intestine ○ K50.80 Crohn's large & small ○ K51.90 Ulcerative Colitis ○ Other ICD-10 Code: _____

Severity: ○ Mild ○ Moderate to Severe ○ Fistulizing Does patient have a latex allergy? ○ Yes ○ No Is patient up to date on Immunizations? ○ Yes ○ No

Prior Failed medications: _____ Reason for discontinuation: _____

Current Medications: _____ Renal Dysfunction: ○ Yes ○ No Current SCr: _____ CrCl: _____ mL/min

Hep B Screening? ○ **Positive** ○ **Negative** **Test date:** ____/____/____ **Has patient received TB/PPD test?** ○ **Yes** ○ **No** **PPD Test date:** ____/____/____ **Result:** _____

Prescription Information

Medication	Dose/ Strength Available	Directions	Quantity	Refills
Cimzia®	○ 200 mg/mL Vial kit ○ 200 mg/mL Prefilled Syringe kit ○ Starter Kit 6 x 200 mg/mL	○ Induction: Inject 400 mg (2 x 200 mg) SC at weeks 0, 2, and 4 ○ Maintenance: Inject 400 mg (2 x 200 mg) every 4 weeks		
○ Humira® ○ Amjevita ™ ○ Cyltezo ™	○ Crohns Pen Starter Kit ○ 40 mg/0.8 mL Pen ○ 40 mg/0.8 mL Prefilled Syringe	○ Induction: Inject 160 mg (4 x 40 mg) SC on day 1, then 80 mg (2 x 40 mg) on day 15 ○ Maintenance : Inject 40 mg SC EVERY OTHER week (beginning on day 29) ○ Maintenance Other: Inject 40 mg SC EVERY week Treatment Pediatric age ≥ 6 yr dosed by weight (HUMIRA only) ○ 17-40 kg Induction: Inject 80 mg (2 x 40 mg) on day 1, then 40 mg on day 15 ○ 17-40 kg Maintenance: Inject 20 mg SC EVERY OTHER week (beginning on day 29) ○ ≥ 40 kg Induction: Inject 160 mg (4 x 40 mg) SC on day 1, then 80 mg (2 x 40 mg) on day 15 ○ ≥ 40 kg Maintenance: Inject 40 mg SC EVERY OTHER week (beginning on day 29)		
○ Remicade® ○ Inflectra® ○ Renflexis™	○ 100 mg Vial	○ Induction: Infuse 5 mg/kg =_____ mg IV at weeks 0, 2, and 6 ○ Maintenance: Infuse 5 mg/kg =_____ mg IV every 8 weeks ○ Maintenance Other: Infuse _____mg IV every 8 weeks Treatment Pediatric age ≥ 6 yr dosed by weight (REMICADE only) ○ Induction: Infuse 5 mg/kg =_____ mg IV at weeks 0, 2, and 6 ○ Maintenance: Infuse 5 mg/kg =_____ mg IV every 8 weeks		
Simponi®	○ 100 mg/ mL SmartJect ○ 100 mg/ mL Prefilled Syringe	○ Induction: Inject 200 mg SC at week 0, then 100 mg at week 2 ○ Maintenance: Inject 100 mg every 4 weeks		
Stelara®	○ 90 mg/mL Prefilled Syringe ○ 130 mg/ 26 mL IV solution	○ Induction: ≤ 55kg: Infuse 260 mg (2 vials) IV at week 0 ○ Induction: 56 kg to 85 kg: Infuse 390 mg (3 vials) IV at week 0 ○ Induction: > 85 kg: Infuse 520 mg (4 vials) IV at week 0 ○ Maintenance: Inject 90 mg SC every 8 weeks (begin dosing 8 weeks after IV induction)		
Entyvio®	○ 300 mg vial	○ Induction: Infuse 300 mg IV at weeks 0, 2, and 6 ○ Maintenance: Infuse 300 mg IV every 8 weeks		
Tysabri®	○ 300 mg/ 15 mL vial	Only prescribers registered in the CD TOUCH® Prescribing Program may prescribe TYSABRI ○ Induction/ Maintenance: Infuse 300 mg IV over 1 hr every 4 weeks		
Entocort® EC	○ 3 mg delayed release capsule	○ Induction of Active Episode: Take 9 mg ONCE daily in the morning for up to 8 weeks of treatment, may repeat 8-week course with recurring active episodes ○ Maintenance of Remission: Take 6 mg once daily for up to 3 months, if symptom control is maintained for 3 months recommended to taper off ○ Induction Pediatric age ≥ 8yr and ≤ 17yr (weigh > 25 kg): Take 9 mg ONCE daily in the morning for up to 8 weeks, then 6 mg ONCE daily for 2 weeks		
Uceris®	○ 9 mg extended release tablet	○ Induction: Take 9 mg PO ONCE daily in the morning for up to 8 weeks of treatment, may repeat 8-week course with recurring active episodes		
Colazal®	○ 750 mg capsule	○ Take 2.25 g (3 capsules) PO Three times daily (may use 8-12 weeks) for _____ weeks Induction Pediatric age ≥ 5yr and ≤ 17yr: ○ Take 750 mg PO Three times daily (up to 8 weeks) for _____ weeks ○ Take 2.25 g (3 capsules) PO Three times daily (up to 8 weeks) for _____ weeks		
Giazo®	○ 1.1 g tablet	○ Adult MALES: Take 3.3 g (3 tablets) PO Twice daily (up to 8 weeks) for _____ weeks		
Asacol® HD	○ 800 mg tablet EC (delayed release)	○ Treatment: Take 1.6 g PO Three times daily on an empty stomach for 6 weeks		
Lialda®	○ 1.2 g tablet	○ Treatment: Take 2.4 g (2 tablets) PO once daily with a meal (may use 6-8 weeks) for _____ weeks ○ Treatment: Take 4.8 g tablet (4 tablets) PO once daily with a meal (may use 6-8 weeks) for _____ weeks ○ Maintenance of Remission: Take 2.4 g (2 capsules) PO daily with a meal		
Apriso®	○ 0.375 g capsule ER 24hr Therapy Pack	○ Maintenance of Remission: Take 1.5 g (4 capsules) PO daily in the morning		
Delzicol®	○ 400 mg capsule delayed release	○ Treatment: Take 800 mg (2 capsules) PO Three times daily for 6 weeks ○ Maintenance of Remission: Take 1.6 g (4 capsules) PO daily in 2-4 divided doses Treatment Pediatric age ≥ 5 yr dosed by weight: ○ 17-32 kg Take 800 mg (2 capsules) PO every AM and 400 mg PO every PM for 6 weeks ○ 33-53 kg Take 1200 mg (3 capsules) PO every AM and 800 mg (2 capsules) PO every PM for 6 weeks ○ 54-90 kg Take 1200 mg (3 capsules) PO every AM and 1200 mg (3 capsules) PO every PM for 6 weeks		
Other: _____				

Prescriber Signature: _____ _____ Date: _____

Dispense as Written Product Substitution Permitted