CROHN'S/ULCERATIVE COLITIS ENROLLMENT FORM
Fax: 270-247-6033 or 270-251-3571

DUNCAN
SPECIALTY PHARMACY

317 W. Broadway
Mayfield, KY 42066
Phone: 270-247-3725

Today's Date: Needs by Date: Ship to: ____Patient ____Office ____Other:

Patient Information	Prescriber Information
Patient Name:	Prescriber Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home & Cell #:	DEA #: State Lic#:
SSN:	NPI#:
DOB: Sex:	Phone: Fax:
Patient Weight: lbs or KG	Contact Person Name:
Drug Allergies:	Contact E-mail:

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible as well as pertinent chart notes related to Patient's diagnosis.

Clinical Information—Statement Of Medical Necessity

Diagnostic Information & Prior Treatment History

ICD-10 code(s): Diagnosis:

ICD-10 code(s): Diagnosis:

TB skin test date and result:

PREVIOUS MEDICATION(S)	DURATION/REASON FOR DISCONTINUING

Prescription Information

✓	MEDICATION		DIRECTIONS	QTY	REFILLS
☐	CIMZIA	☐ 200mg STARTER kit ☐ 400mg kit	☐ INITIATION Dose—Inject 400mg subcutaneously at weeks 0, 2, & 4. ☐ MAINTENANCE Dose—Inject 400mg subcutaneously every 4 weeks		
☐	ENTYVIO	300mg Vial	☐ INTIATION Dose – Infuse 300mg intravenously over 30 minutes at weeks 0,2, & 6 ☐ MAINTENANCE Dose – Infuse 300mg intravenously over 30 minutes every 8 weeks.		
☐	HUMIRA	☐ 40mg/0.8mL Crohn's STARTER kit ☐ 40mg/0.8mL PEN kit ☐ 40mg/0.8mL Pre-filled Syringe Kit	☐ INITIATION Dose - Inject 160mg (4pens) on day 1 followed by 80mg(2pens) on day 15 and 1 pen on day 29 ☐ MAINTENACE Dose – Inject 40mg (1pen) subcutaneously every other week.		
☐	REMICADE	100mg (weight-based dosing)	☐ INITIATION Dose – Infuse 5mg/kg at weeks zero, two, and six. ☐ MAINTENACE Dose – Infuse 5mg/kg every eight weeks		
☐	SIMPONI	100mg Pen	☐ INITIATION Dose – Inject 200mg (2pens) subcutaneously at week zero followed by 100mg(1pen) at week two. ☐ MAINTENANCE Dose – Inject 100mg subcutaneously every 4 weeks.		

By signing this form & utilizing our services, you are authorizing Duncan Specialty Pharmacy & its employees to serve as your prior authorization designated agent in dealing with medical & prescription insurance companies. 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 to another pharmacy of the patient's choice or within his/her provider network.

Prescriber Signature: ____Date: ____________________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error & then destroy this document immediately.