CROHN'S / COLITIS ENROLLMENT FORM

METIER PHARMACY CO. Pharmacy Unscripted

Phone: 602-899-6960 Fax: 602-899-6961

4214 E Indian School Rd Ste 103
Phoenix, Arizona 85018
info@metierpharmacy.com
www.metierpharmacy.com

PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____
Gender: ☐ Male ☐ Female
Primary Language: _____

PRESCRIBER INFORMATION

Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Metier Pharmacy can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

INSURANCE INFORMATION If available, please fax copy of prescription insurance cards with this form(front and back).

MEDICAL INFORMATION

Prior Failed Medication(s):	Reason for Discontinuing	Length of Treatment
☐ 5-ASA ☐ Corticosteroids		___/___/___-___/___/___
☐ Immunosuppressants (6-MP or other)		___/___/___-___/___/___
☐ Methotrexate ☐ Other		___/___/___-___/___/___

Date of Diagnosis: ___/___/___

- ☐ K50.00 Regional enteritis of small intestine
- ☐ K50.10 Regional enteritis of large intestine
- ☐ K50.80 Regional enteritis of small intestine with large intestine
- ☐ K50.90 Regional enteritis of unspecified site
- ☐ K51.80 Ulcerative enterocolitis
- ☐ K51.80 Ulcerative ileocolitis
- ☐ K51.50 Left-sided ulcerative colitis
- ☐ K51.00 Universal ulcerative colitis
- ☐ K51.90 Ulcerative colitis, unspecified

Other: _____

TB/PPD Test Results:
☐ Negative
☐ Positive

Hepatitis B ruled out or being treated:
☐ Yes
☐ No

Allergies: _____

Patient's Weight: _____

Prior biologic use: **Date of last dose:**
☐ Remicade® _____
☐ Humira® _____
☐ Simponi® _____
☐ Cimzia® _____

PRESCRIPTION

Drug		Directions & Quantity	Refills
Cimzia®	☐ Prefilled Syringe ☐ Lyophilized Powder	☐ **INITIAL:** Inject 400mg SQ on day 1, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200mg SQ every 2 weeks (Quantity: 2)	
Humira®	☐ Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160mg SQ on day 1, then 80mg on day 14 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40mg SQ every other week (Quantity: 2)	
Remicade®	☐ Vials	☐ **INITIAL:** Infuse _5mg/___kg=_____mg on day 0, 14, and 42 (Quantity: _____) ☐ **MAINTENANCE:** Infuse _____mg every 8 weeks (Quantity: _____)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 200mg SQ on day 1, then 100mg on day 14 (Quantity: 3) ☐ **MAINTENANCE:** Inject 100mg SQ every 4 weeks (Quantity: 1)	
Entyvio®	☐ 300mg in 20 mL Vial	☐ **Initia/Maintenance:** Week zero, two, and six weeks, then q 8 weeks thereafter	

Other:

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Metier Pharmacy to coordinate injection training/infusion

PHYSICIAN SIGNATURE

Physician Signature: **Date:**