Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

AccuSERV® PHARMACY

Crohn's & Ulcerative Colitis Enrollment Form

Fax: (877) 526-8823

Clear Form

Pharmacy Phone: (866) 213-9821 Single Point of Contact: (724) 515-7053

1. Patient Information

Start Date:_____ Ship to : ☐ Patient ☐ Office _____ Other

Patient Name: _____ ○Male ○Female DOB:_____

Address: _____ Weight:_____

Soc.Sec.# _____Phone#:_____Alt Phone#:_____Height: _____

Caregiver:_____ Allergies: _____Comorbidities:_____

2. Clinical Information

Please fax recent clinical notes, labs & tests with prescription to expedite any prior authorizations

ICD -10/ Diagnosis Code:_____ TB Test ○*yes* ○*no* Date of negative result: _____

Prior biologic use ○*yes* ○*no* Biologic: _____ Date of last dose: _____

Prior History: _____

3. Prescription Information

If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided

✘	Medication	Dose / Strength	Directions *(be specific)*	Quantity	Refills
	Cimzia®	☐ 200mg /mL PFS	Starter Dose ○ inject 400mg Sub-Q at weeks 0,2 & 4	☐ Starter kit(6 PFS)	
			Maintenance Dose ○ inject _____mg Sub-Q every _____ weeks	_____ PFS	
	Humira®	☐ 40mg/ 0.8mL	Induction Dose: ○ inject 160mg Sub-Q Day 1, then 80mg Sub-Q Day 15, then 40mg Sub-Q every other week starting Day 29 ○ inject 80mg Sub-Q Day 1, and Day 2; then 80mg Sub-Q Day 15, then 40mg Sub-Q every other week starting Day 29 Maintenance Dose: ○ inject _____mg Sub-Q every _____ weeks	_____ Pens _____ PFS	
	Remicade®	☐ 100mg / 20mL Vial	○ Use as directed per package instructions ○	○ 1 Vial ○	
	Simponi®	☐ 100mg/mL	Induction Dose: ○ inject 200mg Sub-Q at wk 0, followed by 100mg Sub-Q at wk 2 Maintenance Dose: ○ inject 100mg Sub-Q every 4 weeks	○ 1 PFS ○ 1 *SmartJect®* ○	
	Stelara®	☐ 90 mg/mL PFS	○ inject 90 mg Sub-Q 8 weeks following initial IV dose, then every 8 weeks thereafter	○ 1 PFS ○	
	Symproic®	☐ 0.2 mg	○ take 1 tablet by mouth every day	_____ tablets	
	Trulance®	☐ 3 mg	○ take 1 tablet by mouth every day	_____ tablets	
	Viberzi®	☐ 75 mg ☐ 100 mg	○ take 1 tablet by mouth twice a day	○ 60 tablets	
	Xifaxan®	☐ 200 mg ☐ 550 mg	○ take _____mg by mouth _____ times per day	_____ tablets	

4. Prescriber and Shipping Information

Prescriber (print): _____Office Contact:_____

Pref. Method of Contact: ○phone ○fax ○email Contact email: _____

Office Address: _____

Phone: _____Fax: _____ NPI:_____

Prescriber's Signature:_____Date:_____DEA: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information

Please fax a copy of insurance card front and back. Enlarge if possible.

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.