MAXOR SPECIALTY

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Crohn's Disease/Ulcerative Colitis Enrollment Form

Patient Information

Patient Name__________ ☐Male ☐Female

Date of Birth__________ ☐English ☐Spanish ☐Other__________

Address__________ Apt #__________

City__________ State____ Zip__________

Phone # - Primary__________ Secondary__________

Email Address__________

Social Security #__________

Allergies__________ ☐NKA

Weight__________ ☐kg ☐lb Height__________ ☐in ☐cm

Emergency Contact Name__________

Emergency Contact Phone__________

Please attach copy of insurance information or a copy of insurance card(s) (both sides).

Shipping Information

☐New ☐Refill Date Medication Needed: __________

☐Injection Training Needed

Ship to: ☐Patient's Home ☐Physician's Office
☐Other__________

Medical Information (Please attach or complete all known medical history)

Diagnosis

☐555.0 Regional Enteritis (small intestine) ☐555.1 Regional Enteritis (large intestine)

☐555.2 Regional Enteritis (small w/large intestine) ☐555.9 Regional Enteritis (unspecified site)

☐556.9 Ulcerative Colitis Unspecified ☐Other__________

Has patient received a TB Test? ☐Yes ☐No

Has patient been treated previously for this condition? ☐Yes ☐No

☐NSAIDS__________ Duration________ ☐Sulfasalazine__________ Duration________
☐Corticosteroid__________ Duration________ ☐5-ASA (5-Aminosalicylates)__________ Duration________
☐Methotrexate__________ Duration________ ☐6-MP (6-mercaptopurine)__________ Duration________
☐Azathioprine__________ Duration________ ☐Biologics (list)__________ Duration________
☐Other__________

Is patient currently on therapy? ☐Yes ☐No

☐NSAIDS__________ Duration________ ☐Sulfasalazine__________ Duration________
☐Corticosteroid__________ Duration________ ☐5-ASA (5-Aminosalicylates)__________ Duration________
☐Methotrexate__________ Duration________ ☐6-MP (6-mercaptopurine)__________ Duration________
☐Azathioprine__________ Duration________ ☐Biologics (list)__________ Duration________
☐Other__________

Additional medical rationale for treatment

☐No response to previous treatment__________ ☐Contraindications to other treatments__________

☐Side effects, lab abnormalities, toxicity issues with other treatments (list)__________

☐Other__________

Physician Information

Physician Name__________

Physician NPI__________ License #__________

Office Contact Name__________

Address__________ Ste #__________

City__________ State____ Zip__________

Phone__________ Fax__________

By signing this form, I authorize Maxor Specialty to act as my agent for Prior Authorizations & Prescription Reimbursement for the above listed patient.

Physician Signature__________

Date__________

☐Dispense as written ☐Product substitution permitted

****For Ohio patients, please only choose one (1) prescription per form.****

***Patient Authorization:** I authorize Maxor Specialty to enroll me in the applicable manufacturer's patient support program above to receive services such as, but not limited to, injection training. I further authorize Maxor Specialty to share minimum necessary information about my health condition and treatment to the manufacturer's program to provide educational materials on my related diagnosis, delivery of products and services offered by the program, and aggregated de-identified data for market analysis. I understand that I may revoke this authorization at any time by contacting Maxor Specialty. I also undertand that I may refuse to sign this authorization and I will still be eligible for treatment by Maxor Specialty.

Patient Signature__________ Date__________

Prescription Information

Cimzia® (Crohn's Indication)
Initial Dose:
☐400 mg SQ on day 0, 2, and 4 then maintenance dose
Quantity__________ Refill__________ times

☐**Enroll in CIMplicity™ Program***
Maintenance Dose:
☐400 mg SQ every 4 weeks
☐Other__________

Humira® (Crohn's and Ulcerative Colitis Indication)
Initial Dose:
☐Inject 160 mg SQ as 4 injections on day 1, 80 mg on day 15
OR
☐Inject 160 mg SQ as 2 injections on days 1 & 2, 80 mg on day 15
Quantity__________ Refill__________ times

☐**Enroll in MyHumira® Program***
Maintenance Dose:
☐Inject 40 mg SQ every other week
☐40 mg/0.8 ml, PEN (2 pens/box)
☐40 mg/0.8 ml, PFS (2 pfs/box)

Remicade® (Crohn's and Ulcerative Colitis Indication)
Initial Dose:
Infuse Remicade in NS 250 ml over 2 hours as directed
☐5 mg/kg IV at 0, 2, and 6 weeks, then maintenance dose
☐Infusion Supplies Needed
Quantity__________ Refill__________ times

☐**Enroll in AccessOne℠ Program***
Maintenance Dose:
☐5 mg/kg IV every 8 weeks

☐**Simponi®** (Ulcerative Colitis Indication)
Initial Dose:
☐200 mg SQ @ week 0, 100 mg @ week 2, then maintenance dose
Quantity__________ Refill__________ times

☐**SimponiOne® Support***
Maintenance Dose:
☐100 mg SQ every 4 weeks starting @ week 6

☐**Epinephrine Autoinjector** (2-pak)
0.3 mg /0.3 ml, (specify brand) __________
Quantity__________ Refill__________ times

All injection supplies including needles & syringes will be provided with medication if required.

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