

**Prescription & Enrollment Form  
Crohn's Disease**



**(800) 962-6339 Office  
(866) 755-6339 Fax**

Patient Information

Last Name		First Name	
Social Security #		Date of Birth	
Parent or Guardian			
Home Phone		Other Contact Phone	
Home Address			
City, State, Zip			

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

**DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnosis)**

<input type="checkbox"/> 555.9 Crohn's - regional <input type="checkbox"/> 555.0 Small Intestine <input type="checkbox"/> 555.1 Large Intestine <input type="checkbox"/> Other ICD 9	
Fistulizing Crohn's <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Does Patient have CHF? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Diagnosis:
Patient Weight                      lb/kg	Allergies:
Patient Height	

**PRESCRIPTION INFORMATION**

<input type="checkbox"/> Cimzia® 400mg	Directions:	Qty:
		Refills:
<input type="checkbox"/> Humira® <input type="checkbox"/> 40mg Crohn's Starter Kit <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Prefilled Syringe	Directions:	Qty:
		Refills:
<input type="checkbox"/> Remicade® 100mg	Directions:	Qty:
		Refills:

**SUPPLIES NEEDED (if medication is to be administered in the patient's home):**

If checked, please specify the size and type (if applicable):

- Syringes/Needles     
  Swabs     
  Sharps Container     
  Other

**ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:**

**DELIVERY INSTRUCTIONS**

<input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other	Date Medication Needed:
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Physician's Name (Please Print)

Physician's Address

Phone    Fax

Dr.'s Office Contact Name

Physician's Signature    Date

Physician's DEA#

License #    NPI

**Fax completed form to Medex BioCare (866) 755-6339**