Sunray Specialty Pharmacy

Crohn's/UC Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____
Alternate Phone: _____
DOB: _____
Last 4 Digits of SS#: _____
Gender: _____
Language Preference: _____

PRESCRIBER INFORMATION:

Prescriber's Name: _____
DEA: _____
NPI: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact Person's Phone: _____

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

BIN: _____ PCN: _____ Rx Group: _____ ID #: _____ Prior Authorization Reference #: _____

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications
☐ Other Diagnosis:
ICD-10 Code: _____
Description: _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No

Additional information:

Weight: _____ kg/lb Height _____ cm/in
Allergies: _____
Lab Data: _____
Prior Therapies: _____
Concomitant Medications: _____
_____
Injection Training Required: ☐ Yes ☐ No
Start Date _____Review Date _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Cimzia®	☐200mg/mL Prefilled Syringe Starter Kit ☐200mg/mL Prefilled Syringe ☐200mg/mL Vial Kit			
Humira®	☐20mg/0.4mL PFS ☐20mg/0.2mL PFS ☐40mg/0.8mL PFS ☐40mg/0.4mL PFS ☐40mg/0.8mL PFS (Pediatric CD Starter Pack) ☐80mg/0.8mL & 40mg/0.4mL PFS (Pediatric CD Starter Pack) ☐80mg/0.8mL PFS (Pediatric Starter Pack) ☐40mg/0.8mL Pen ☐40mg/0.4mL Pen ☐40mg/0.8mL Pen (CD/UC/HS Starter Pack) ☐80mg/0.8mL Pen (CD/UC/HS Starter Pack)			
Inflectra®	☐100mg Vial			
Remicade®	☐100mg Vial			
Renflexis®	☐100mg Vial			
Simponi®	☐100 mg/mL Prefilled Syringe ☐100 mg/mL SmartJect Autoinjector			
Stelara®	☐90 mg/mL Prefilled Syringe ☐130mg/26mL Vial			
Tysabri®	☐300mg Vial			
Xeljanz®	☐5mg Tablet ☐10mg Tablet			
OTHER: _____				

Please deliver to: ☐Patient ☐Office ☐Other _____ by this date: _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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 related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution Permitted ☐ Dispense as Written

Prescriber's Signature: _____