

Today's Date

NEW PATIENT CURRENT PATIENT

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 Diagnosis: Crohn's Disease 555.0 555.1 555.2 555.9 Ulcerative Colitis 555.0 555.1 555.2 555.9
 TB/PPD Test given? Yes No Chest X-Ray Yes No Results _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____
 Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRIOR | CURRENT TREATMENTS

Treatment	Dose Duration	Treatment	Dose Duration	Treatment	Dose Duration
<input type="checkbox"/> Azathioprine	_____	<input type="checkbox"/> 5-ASA	_____	<input type="checkbox"/> Methotexate	_____
<input type="checkbox"/> Corticosteroids	_____	<input type="checkbox"/> 6-MP	_____	<input type="checkbox"/> Sulfasalazine	_____
<input type="checkbox"/> Remicade	_____	<input type="checkbox"/> NSAIDS	_____	<input type="checkbox"/> Other: List	_____

HUMIRA

STARTER Day 1: Inject 160mg (4 pens) SQ. Day 1: Inject 80mg (2 pens) SQ, Day 15: maintenance
 MAINTENANCE Inject (1 Pen) 40mg/0.8ml every other week
 Other _____
 QUANTITY 4 week supply Refill X _____

CIMZIA

STARTER 400mg SQ initially and at week 2 & 4
 MAINTENANCE 400 mg SQ every 4 weeks
 QUANTITY 4 week supply Refill X _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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