Crohn's Disease Enrollment Form

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Choice Infusion Center "Infuse to better health"

Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** __ Male __ Female **Height:** _____ **Weight:** _____ lbs. _____ kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Patient Insurance Information

Subscriber Name: _____ **Primary Medical Insurance:** _____ **Primary Insurance Form:** _____

Policy Number: _____ **Group Number:** _____ **Prescription Card BIN #:** _____ **PCN #:** _____

Treatment Arrangement

Start Date: _____ **Ship Meds:** __ **Home** __ **Doctor's Office** **Teaching By:** __ **Home Health** __ **Doctor's Office** **Others:** _____

Statement of Medical Necessity

Diagnosis (ICD-9 Code):

__ 555.0 Regional Enteritis or Crohn's Disease of Small Intestine

__ 555.0 Regional Enteritis or Crohn's Disease of Large Intestine

__ 555.0 Regional Enteritis or Crohn's Disease NOS

Other: _____ Date of Diagnosis: _____

Prior (Failed) Medications:

Medication / Strength / Duration of Treatment / Reason for D/C

Biologics (list): _____

_____

5-ASA: _____

Azathioprine: _____

Corticosteroids: _____

Methotrexate: _____

6-MP: _____

Sulfasalazine: _____

Others: _____

Patient's Evaluation:

__ **Crohn's Severity** __ Moderate __ Severe

__ **Enterocutaneous/rectoviginal Fisyulas?** __ Yes __ No

__ **Has patient been diagnosed with Heart Failure?** __ Yes __ No

__ **Has patient been diagnosed with Lymphoma?** __ Yes __ No

__ **Does patient have serious /active infection?** __ Yes __ No

__ **Has TB test been performed?** __ Yes __ No

If Yes, Results: _____ Comments: _____

__ **Is patient at risk for Hepatitis B infection?** __ Yes __ No

If Yes, has Hepatitis B been ruled out or treatment iniated? __ Yes __ No

__ **Does patient have a latex allergy?** __ Yes __ No

__ **Are there any contraindications to previous treatments ?** __ Yes __ No

If Yes, Drug: _____ Reason: _____

__ **Allergies:** _____

__ **Concomitant Medications:** _____

Prescription Information

Medication	Strength	Directions	Quantity	Refills
__ **Cimzia®**	__ 200mg/1ml Prefilled Syringe __ 200	**Induction Dose:** Inject 400mg (2 vials) subcutaneously on day 1, week 2, week 4.	3 kits (6 vials)	
		Maintenance Dose: Inject 400mg (2 vials) subcotaneously every 4 week	1 kit	
__ **Remicade®**	__ 100mg vials _____mg/kg	**Induction Dose:** IV at 5mg/kg (Dose=_____mg) at 0, 2, and 6 weeks. **Maintenance Dose:** IV at 5mg/kg (Dose= _____mg) every 8 weeks. **Other:**	# of 100mg vial	

Physician Signature: _____ **DAW (Dispense as Written) Date:** _____

Physician Name: _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

Physician Address: _____ **NPI:** _____