CuraScript

Crohn's Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND FAX TO: 1-888-773-7386 or Call: 1-888-773-7376

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information ☐ New Rx ☐ Refill

Name: ____________________
Phone #1: __________ Phone #2: __________
Address: ____________________
Allergies: ____________________ ☐ No Known Allergies
City: __________ ST: ____ Zip: ______
Health Conditions: ____________________
Date of Birth (mm/dd/yyyy): __ __ / __ __ / __ __ __ __
Expected Start Date: __ __ / __ __ / __ __

Statement of Medical Necessity

Patient Weight: ______ ☐ lbs ☐ kg
Blood Pressure: ________
Date: __ __ / __ __ / __ __
Primary Diagnosis: ____________________ **ICD9 Code:** ____________________

Other reasons for treatment (complete or attach medical history)

No response to previous treatment: ____________________
Contraindications to other treatments: ____________________
Side effects: ____________________
Other: ____________________

Drug Delivery Information

If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

☐ In Office Delivery ☐ Home Delivery for Self Injection/Administration
☐ Home Delivery for Home Health Administration
Other: ____________________
Contact: ____________________
Phone #: ____________________
Address: ____________________

Insurance Information

Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: ____________________
Insured: ____________________
ID #: __________ Group #: __________
Phone #: __________ Rx Drug Card #: __________
Rx Bin #: ______ Rx PCN #: ____ Rx Grp #: ______

Secondary: ____________________
Insured: ____________________
ID #: __________ Group #: __________
Phone #: __________ Rx Drug Card #: __________
Rx Bin #: ______ Rx PCN #: ____ Rx Grp #: ______

Doctor/Prescriber Information

NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: ____________________
Address: ____________________
City: __________ ST: ____ Zip: ______
Office Contact: ____________________
NPI #: __________ DEA #: __________
Phone #: __________ Fax #: __________

2. COMPLETE THE FOLLOWING Rx FORM –OR– TAPE Rx HERE

Rx

Date: __ __ / __ __ / __ __

Drug Name/Form/Strength	Qty	Directions for Use	Refills
☐ **CIMZIA**® 200 mg vial ☐ **CIMZIA**® 200 mg/mL Pre-Filled Syringe 2-pack			
☐ **HUMIRA**® 40mg/0.8mL Pen Kit ☐ **HUMIRA**® 40mg/0.8mL Prefilled Syringe Kit ☐ **HUMIRA**® 40mg/0.8mL Crohn's Disease Starter Package Pen Kit			
☐ **REMICADE**® 100mg Vial (weight-based dosing)			
Other:			

Needles Gauge: ____ Inches: ___ Quantity: ___ Refills: ___ **Syringes** Volume: ____ Inches: ___ Quantity: ___ Refills: ___

X ____________________
Doctor/Prescriber Signature – Dispense as Written
Stamped signatures cannot be accepted

X ____________________
Doctor/Prescriber Signature – Substitution Permissible
Stamped signatures cannot be accepted

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.

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