LINDEN
RETAIL SPECIALTY PHARMACY

INFLAMMATORY BOWEL DISEASE ENROLLMENT FORM

Phone: 908-583-6665 | Fax: 888-474-0976

Email: lindensprx@gmail.com

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____

Address: _____ City, State, ZIP: _____

Preferred Contact Methods:

☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____ Date Of Birth: _____

Gender: ◯ Male ◯ Female Email: _____

Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____

State License Number: _____ NPI Number: _____ DEA Number: _____

Group or Hospital: _____ Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Contact Person: _____ Contact Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ K50.00 Crohn's Disease of Small Intestine Without Complications
☐ K50.10 Crohn's Disease of Large Intestine Without Complications
☐ K50.80 Crohn's Disease of Small & Large Intestine Without Complications
☐ K50.90 Crohn's Disease, Unspecified, Without Complications
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.30 Ulcerative (chronic) rectosigmoiditis without complications
☐ K51.50 Left sided colitis without complications
☐ K51.90 Ulcerative colitis, unspecified, without complications
☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

TB Test Result: _____ Date: _____

Nursing:

Specialty pharmacy to coordinate injection training/ home health infusion nurse visit necessary ◯ Yes ◯ No

Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

Injection training not necessary. Date training occurred: _____

Reason: ☐ MD office training patient ☐ PT already independent ☐ Referred by MD to alternate trainer

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Medications A-R

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Please complete Patient and Prescriber information

Patient Name: _____ Patient Date Of Birth: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Induction Dose: Inject SC 400mg (2 injections) on day 1, and at weeks 2 and 4. If response occurs, follow with 400 mg every four weeks	Quantity: 1 kit (6 prefilled syringes) Refills: 0
☐ Cimzia	☐ 200 mg/1 mL Prefilled Syringe ☐ 200 mg vial	Maintenance Dose: Inject SC 400 mg (2 injections) every 4 weeks.	Quantity: _____ Refills: _____
☐ Entyvio	☐ 300 mg in a single dose vial in individual carton	Recommended dosage in UC & CD: 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks, then every 8 weeks thereafter.	Quantity: _____ Refills: _____
☐ Humira	☐ Crohn's Disease, Ulcerative Colitis 40 mg/0.4 mL Starter Package **Citrate Free** ☐ Crohn's Disease, Ulcerative Colitis 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package **Citrate Free**	Induction Dose: Inject SC 160 mg on day 1, then 80 mg on day 15, then maintenance on day 29	Quantity: 1 package Refills: 0
☐ Humira	☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 mL Prefilled Syringe **Citrate Free**	Maintenance Dose: Inject one 40 mg pen/syringe SC every other week	Quantity: _____ Refills: _____
☐ Inflectra	100 mg vial	☐ Induction Dose: IV at 5 mg/kg (Dose = ____ mg) at week 0, week 2, week 6 and every 8 weeks thereafter ☐ Maintenance Dose: IV at 5 mg/kg (Dose = ____ mg) every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
☐ Remicade	100 mg vial	☐ Induction Dose: IV at 5 mg/kg (Dose = ____ mg) at week 0, week 2, week 6 and every 8 weeks thereafter ☐ Maintenance Dose: IV at 5 mg/kg (Dose = ____ mg) every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
☐ Renflexis	100 mg vial	☐ Induction Dose: IV at 5 mg/kg (Dose = ____ mg) at week 0, week 2, week 6 and every 8 weeks thereafter ☐ Maintenance Dose: IV at 5 mg/kg (Dose = ____ mg) every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____

5 PHYSICIAN SIGNATURE REQUIRED

Product Substitution Permitted _____ (Date) _____

Dispense as Written _____ (Date) _____

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Prescriber Name: _____ Prescriber Phone: _____

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☐ Cimzia	☐ 200 mg/1 mL Prefilled Syringe ☐ 200 mg vial	Maintenance Dose: Inject SC 400 mg (2 injections) every 4 weeks.	Quantity: _____ Refills: _____
☐ Entyvio	☐ 300 mg in a single dose vial in individual carton	Recommended dosage in UC & CD: 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks, then every 8 weeks thereafter.	Quantity: _____ Refills: _____
☐ Humira	☐ Crohn's Disease, Ulcerative Colitis 40 mg/0.4 mL Starter Package **Citrate Free** ☐ Crohn's Disease, Ulcerative Colitis 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package **Citrate Free**	Induction Dose: Inject SC 160 mg on day 1, then 80 mg on day 15, then maintenance on day 29	Quantity: 1 package Refills: 0
☐ Humira	☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 mL Prefilled Syringe **Citrate Free**	Maintenance Dose: Inject one 40 mg pen/syringe SC every other week	Quantity: _____ Refills: _____
☐ Inflectra	100 mg vial	☐ Induction Dose: IV at 5 mg/kg (Dose = _____ mg) at week 0, week 2, week 6 and every 8 weeks thereafter ☐ Maintenance Dose: IV at 5 mg/kg (Dose = _____ mg) every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
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☐ Renflexis	100 mg vial	☐ Induction Dose: IV at 5 mg/kg (Dose = _____ mg) at week 0, week 2, week 6 and every 8 weeks thereafter ☐ Maintenance Dose: IV at 5 mg/kg (Dose = _____ mg) every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____

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Please complete Patient and Prescriber information

Patient Name: _____ Patient Date Of Birth: _____

Prescriber Name: _____ Prescriber Phone: _____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Inflectra	☐ 100mg/mL in a single-dose prefilled SmartJect® autoinjector ☐ 100 mg/mL in a single-dose prefilled syringe	☐ Induction Dose: Inject SC 200 mg initially (given as 2 subcutaneous injections of 100 mg each) at Week 0, followed by 100 mg at Week 2 and then 100 mg every 4 weeks ☐ Maintenance Dose: Inject SC 100 mg every 4 weeks ☐ Other: _____	Quantity: _____ Refills: _____
☐ Stelara	☐ 130 mg/26 mL (5 mg/mL) IV single-dose vial Date Infusion was completed or scheduled: _____. (This date is needed to determine shipment of Stelara SC maintenance dosage)	Single IV Induction Dose: ☐ 55 kg or less 260 mg at Week 0: # of vials to be used 2 ☐ more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 3 ☐ more than 85 kg 520 mg at Week 0: # of vials to be used 4 ☐ Other: _____	Quantity: ☐ 2 Vials ☐ 3 Vials ☐ 4 Vials Refills: 0
☐ Stelara	90 mg/mL SC dose in a single-dose prefilled syringe	☐ 90 mg SC dose 8 weeks after the initial IV induction dose, then every 8 weeks thereafter ☐ Other: _____	Quantity: _____ Refills: _____
☐ Tysabri	NA	Please complete a MS TOUCH®/Tysabri enrollment form and indicate Linden Retail Specialty Pharmacy as your preferred pharmacy provider. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255)	Quantity: 0 Refills: 0
☐ Xeljanz	☐ 5 mg ☐ 10 mg	☐ 10 mg twice daily for at least 8 weeks; followed by 5 or 10 mg twice daily, depending on therapeutic response. Use the lowest effective dose to maintain response. Discontinue Xeljanz after 16 weeks of treatment with 10 mg twice daily, if adequate therapeutic benefit is not achieved. ☐ Other: _____	Quantity: _____ Refills: _____

Complete Items below, required for Home Infusion/Coram AIS:

MEDICATION / SUPPLIES	ROUTE	DOSE & DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PORT ☐ PICC	☐ IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days) PORT/PICC – NS 10ml & Heparin 100units/ml 3-5ml, and/or 10ml sterile saline to access port a cath	Quantity: _____ Refills: _____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3mL (15-30kg/33-66lbs) ☐ Infant 0.1mL/0.1mL, 0.1mL (7.5-15kg/16.5-33lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity: _____ Refills: _____

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