

Crohn's Patient Enrollment Form

Phone: 800.604.6068
 Fax: 800.599.5560



BURMANS
 SPECIALTY PHARMACY

Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Patient Soc. Sec # _____ Date of Birth: ___/___/___ Sex: Male Female Weight: _____ See attached demographic sheet	Physician Name: _____ State Lic. # _____ DEA # _____ UPIN # _____ Practice Name/Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Physician's Ph: _____ Physician's Fax: _____ Nurse/Key Office Contact: _____ Ship to: Patient Physician Date Shipment Needed: _____
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Insurance Information (complete or attach copies of cards)

Primary Insurance: _____ City: _____ State: _____ Phone: _____	Cardholder Name: _____ ID # _____ Group # _____ Employer: _____	Prescription Card: _____ City: _____ State: _____ Phone: _____
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Diagnostic Information

<input type="checkbox"/> Crohn's Disease (555.0, 555.1, 555.2, 555.9) <input type="checkbox"/> Other _____	Humira: TB/PPD Test given? <input type="checkbox"/> Yes <input type="checkbox"/> No Weight: _____ lbs or _____ kg
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Prior/Current Treatments

<input type="checkbox"/> NSAIDs _____ <input type="checkbox"/> Corticosteroids _____ <input type="checkbox"/> Methotrexate _____ <input type="checkbox"/> Azathioprine _____ <input type="checkbox"/> Remicade _____ <input type="checkbox"/> Sulfasalazine _____ <input type="checkbox"/> 5-ASA _____ <input type="checkbox"/> 6-MP _____ <input type="checkbox"/> Biologics (list) _____ <input type="checkbox"/> Other (list) _____	Drug Allergies: <input type="checkbox"/> No known Drug Allergies <input type="checkbox"/> Allergies (list): _____ _____ _____ <input type="checkbox"/> Other medications (attach list): _____ _____ _____
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Prescription Information

A. HUMIRA: Starter Pack	B. Humira: Ongoing Therapy
<input type="checkbox"/> Crohn's Disease Starter Pack: Humira Self-Injectable Pen 40mg/0.8ml. NDC: 00074-4339-06	<input type="checkbox"/> Humira Self-Injectable Pen 40mg/0.8ml. NDC: 00074-4339-02 <input type="checkbox"/> Humira Pre-filled Syringe 40mg/0.8ml. NDC: 00074-3779-02
<input type="checkbox"/> Four 40 mg subq injections day 1, two 40 mg subq injections day 15 <input type="checkbox"/> Two 40mg subq injections day 1, Two 40mg subq injections day 2, Two 40mg subq injections day 15	<input type="checkbox"/> 40 mg subq injection every other week <input type="checkbox"/> Other: _____
Quantity to be dispensed: <input type="checkbox"/> 28 day supply	No Refills
Quantity to be Dispensed: <input type="checkbox"/> 28 day supply, <input type="checkbox"/> 84 day supply, <input type="checkbox"/> Other: _____	Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

Physician's Signature: _____ DAW (Dispense as Written) Date ___/___/___
 "Will dispense available generic unless DAW is marked"