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***:_________

Insurance Information (complete or attach copies of cards)

Primary Insurance:___________________________
City:______________________State:______
Phone:_____________________________________

Cardholder Name:___________________________
ID #______________Group #______________
Employer:__________________________________

Prescription Card:__________________________
City:______________________State:______
Phone:_____________________________________

Diagnostic Information

☐ Crohn's Disease (555.0, 555.1, 555.2, 555.9)
☐ Other______________________________

Humira: TB/PPD Test given? ☐ Yes ☐ No
Weight: _____________lbs or _____________kg

Prior/Current Treatments

☐ NSAIDs ____
☐ Corticosteroids ____
☐ Methotrexate ____
☐ Azathioprine ____
☐ Remicade ____
☐ Sulfasalazine ____
☐ 5-ASA ____
☐ 6-MP ____
☐ Biologics (list) ____
____
☐ Other (list) ____
____

Drug Allergies: ☐ No known Drug Allergies
☐ Allergies (list): ________________________________
____
____
____
____

☐ Other medications (attach list): ____________________
____
____
____
____

Physician's Signature:____

☐ DAW (Dispense as Written) Date____/____/____
"Will dispense available generic unless DAW is marked"

[illegible]