INFLAMMATORY BOWEL DISEASE

E-SCRIBE and FAX ENROLLMENT FORM

☐ **NOBLE NORTHEAST:** E-Scribe: **NOBLE** | Fax: **888-842-3977** | Tel: 888-843-2040

☐ **NOBLE SOUTHEAST:** E-Scribe: **NOBLEMS/TRANSCRIPT** | Fax: **601-420-4040** | Tel: 866-420-4041

Delivery Needed By: ____________ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other: __________

PATIENT INFORMATION	PROVIDER INFORMATION
Patient Name: ____________ ☐ Male	Prescriber's Name: ____________
Street Address: ____________ ☐ Female	Office Contact Name: ____________
City: ________ State: ____ Zip Code: ______	Address: ____________
Phone Number: ____________	City: ________ State: ____ Zip Code: ______
Email Address: ____________	Phone Number: ________ Fax Number: ________
Last Four of Social: ________ Date of Birth: ________	DEA/NPI #: ____________

INSURANCE - PLEASE FAX A COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ____________

ICD-10 Code: ____________

Height: ______ft ________ ins Weight: ______ lbs

Allergies: ____________

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: ____________

Medications On: ____________

Other Notes: ____________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Cimzia®	☐ 200mg/ml prefilled syringe	**Loading Dose:** ☐ Inject 400mg SC at weeks 0,2, and 4 **Maintenance Dose:** ☐ Inject 200mg SC every other week ☐ Inject 400mg SC every 4 weeks	☐ 4-week supply	
Entyvio®	☐ 300mg vial	**Loading Dose:** ☐ Infuse 300mg via IV at weeks 0, 2, and 6 **Maintenance Dose:** ☐ Infuse 300mg via IV every 8 weeks	☐ 4-week supply ☐ 8-week supply	
Humira® **(Citrate-Free)**	☐ 40mg/0.4ml pen ☐ 40mg/0.4ml prefilled syringe	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once a week	☐ 4-week supply	
Humira® *Crohn's Starter Kit/UC/HS* **(Citrate-Free)**	☐ 40mg/0.8ml pen x6 ☐ 80mg/0.8ml Pen x3	☐ Inject 160mg SC day 1 and 80mg on day 15, maintenance beginning on day 29 ☐ Inject 80mg day 1 and 80mg day 2, then 80mg on day 15, maintenance beginning on day 29 ☐ Other	☐ 4-week supply	
Inflectra®	☐ 100mg vial	**Loading Dose:** ☐ Infuse 5mg/kg (Dose ____mg) via IV at 0, 2 and 6 weeks, then every 8 weeks thereafter **Maintenance Dose:** ☐ Infuse 5 mg/kg (Dose ______mg) via IV every 8 weeks ☐ Other	☐ ________ vials	
Rayos®	☐ 1mg tablet ☐ 2mg tablet ☐ 5mg tablet	☐ Take ______mg by mouth once per day ☐ Other	☐ 4-week supply	

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Physician Signature: ____________________ Date: ____________________

NATIONALLY ACCREDITED. **100% EMPLOYEE OWNED.**

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Phone Number: ____________	City: ________ State: ____ Zip Code: ______
Email Address: ____________	Phone Number: ________ Fax Number: ________
Last Four of Social: ________ Date of Birth: ________	DEA/NPI #: ____________

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CLINICAL INFORMATION

Diagnosis: ____________

ICD-10 Code: ____________

Height: ______ft ______ ins Weight: ______ lbs

Allergies: ____________

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: ____________

Medications On: ____________

Other Notes: ____________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Remicade®	☐ 100mg vial	<u>Loading Dose:</u> ☐ Infuse 5mg/kg (Dose ____mg) via IV at 0, 2 and 6 weeks, then every 8 weeks thereafter <u>Maintenance Dose:</u> ☐ Infuse 5 mg/kg (Dose ______mg) via IV every 8 weeks ☐ IV _______ every ______ weeks ☐ Other	☐ 4-week supply	
Renflexis®	☐ 100mg vial	<u>Loading Dose:</u> ☐ Infuse 5mg/kg (Dose ____mg) via IV at 0, 2 and 6 weeks, then every 8 weeks thereafter <u>Maintenance Dose:</u> ☐ Infuse 5 mg/kg (Dose ______mg) via IV every 8 weeks ☐ Other	☐ 4-week supply	
Simponi®	<u>Prefilled Syinge:</u> ☐ 50mg/0.5ml ☐ 100mg/1ml <u>SmartJect Autoinjector:</u> ☐ 50mg/0.5ml ☐ 100mg/1ml	☐ Inject 100 mg SC once a month ☐ Inject 50 mg SC once a month ☐ Other	☐ 4-week supply	
Stelara®	☐ 130/26ml single dose vial ☐ 90mg/ml prefilled syringe (Maintenance dosing only)	<u>Loading Dose:</u> ☐ Infuse ____ mg IV as directed by the prescriber <u>Maintenance Dose:</u> ☐ Inject 90mg SC 8 weeks after induction infusion then continue every 8 weeks ☐ Other **Date of Inital Infusion - *______________________***	☐ 8-week supply	
Xeljanz®	☐ 5mg tablet ☐ 10mg tablet	☐ Take one tablet twice a day ☐ Take one tablet once a day ☐ Other	☐ 4-week supply	

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Physician Signature: ____________________ Date: ____________________

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