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: ______________

Has the patient been treated previously for this condition?

ICD-10 Code: ______________

☐ Yes ☐ No

Height: ________ft ________ ins Weight: ________ lbs

Medications Failed: ______________

Allergies: ______________

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	
Dupixent®	☐ 300mg/2ml single dose prefilled syringe ☐ 300mg/2ml single dose prefilled pen	☐ Inject 300mg subcutaneously every week (eosinophilic esophagitis)	☐ 30-day supply ☐ 90-day 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® Adult *Crohn's/ UC/HS* **(Citrate-Free)**	☐ 80mg/0.8ml pen x3 *(Starter Kit)*	☐ 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.	☐ 4-week supply	
Humira® *Pediatric Crohn's Disease (age 6 and older)* 17kg (37lb) to <40kg (88lb) **(Citrate-Free)**	☐ 80mg/0.8ml prefilled syringe x1 and 40mg/0.4ml prefilled syringe x1 *(Starter Kit)* ☐ 20mg/0.2ml prefilled syringe x2 *(Maintenance dosing only)*	**Loading Dose:** ☐ Inject 80mg SC day 1 and 40mg on day 15, then 20mg SC every other week beginning on day 29. **Maintenance Dose:** ☐ Inject 20mg SC every other week.	☐ 4-week supply	

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: ______________ Date: ______________

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

www.noblehealthservices.com

Important Notice: This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy. Q220222

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:
Humira® *Pediatric Crohn's Disease (age 6 and older)* 40kg (88lb) and greater **(Citrate-Free)**	☐ 80mg/0.8ml prefilled syringe x3 *(Starter Kit)* ☐ 80mg/0.8ml pen x3 *(Starter Kit)* ☐ 40mg/0.4ml prefilled syringe x2 *(Maintenance dosing only)* ☐ 40mg/0.4ml pen x2 *(Maintenance dosing only)*	**Loading Dose:** ☐ Inject 160mg SC day 1 and 80mg on day 15, then 40mg SC every other week beginning on day 29. ☐ Inject 80mg SC days 1, 2, and 15, then 40mg SC every other week beginning on day 29. **Maintenance Dose:** ☐ Inject 40mg SC every other week.	☐ 4-week supply	
Humira® *Pediatric Ulcerative Colitis (age 5 and older)* 20kg (44lb) to <40kg (88lb) **(Citrate-Free)**	☐ 40mg/0.4ml pen carton x2 ☐ 40mg/0.4ml pen x2 *(Maintenance dosing only)* ☐ 20mg/0.2ml prefilled syringe x2 *(Maintenance dosing only)*	**Loading Dose:** ☐ Inject 80mg SC day 1 and 40mg on days 8 and 15. Begin maintenance on day 29. **Maintenance Dose:** ☐ Inject 40mg SC every other week. ☐ Inject 20mg SC every week.	☐ 4-week supply	
Humira® *Pediatric Ulcerative Colitis (age 5 and older)* 40kg (88lb) and greater **(Citrate-Free)**	☐ 80mg/0.8ml pen x4 *(Starter Kit)* ☐ 80mg/0.8ml pen x2 *(Maintenance dosing only)* ☐ 40mg/0.4ml pen x2 *(Maintenance dosing only)* ☐ 40mg/0.4ml prefilled syringe x2 *(Maintenance dosing only)*	**Loading Dose:** ☐ Inject 160mg SC day 1 and 80mg on days 8 and 15. Begin maintenance on day 29. ☐ Inject 80mg SC days 1, 2, 8, and 15. Begin maintenance on day 29. **Maintenance Dose:** ☐ Inject 80mg SC every other week. ☐ Inject 40mg SC every week.	☐ 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	

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

Physician Signature: ______________________ Date: ______________________

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

www.noblehealthservices.com

Important Notice: This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy. Q220222

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: ______________

Has the patient been treated previously for this condition?

ICD-10 Code: ______________

☐ Yes ☐ No

Height: ________ft ________ ins Weight: ________ lbs

Medications Failed: ______________

Allergies: ______________

Medications On: ______________

Other Notes: ______________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Rayos®	☐ 1mg tablet ☐ 2mg tablet ☐ 5mg tablet	☐ Take ______mg by mouth once per day. ☐ Other	☐ 4-week supply	
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 5mg/kg (Dose ______mg) via IV every 8 weeks. ☐ Other	☐ 4-week supply	
Rinvoq®	☐ 15mg tablets ☐ 30mg tablets ☐ 45mg tablets	<u>Induction Dose:</u> ☐ Take 1 tab (45mg) by mouth daily for 8 weeks. <u>Maintenance Dose:</u> ☐ Take 1 tab (15mg) by mouth daily. ☐ Take 1 tab (30mg) by mouth daily.	☐ 28 tablets w/ 1 refill ☐ 30 tablets ☐ 90 tablets	
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	

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

Physician Signature: ______________ Date: ______________

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

www.noblehealthservices.com

Important Notice: This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy. Q220222

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: ______________

Has the patient been treated previously for this condition?

ICD-10 Code: ______________ ☐ Yes ☐ No

Height: ________ft __________ ins Weight: ________ lbs

Medications Failed: ______________

Allergies: ______________

Medications On: ______________

Other Notes: ______________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
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	☐ 30-day supply ☐ 90-day supply	
Xeljanz® XR	☐ 11mg tablet ☐ 22mg tablet	☐ Take one tablet once a day. ☐ Other	☐ 30-day supply ☐ 90-day supply	
Zeposia	☐ 7-day Starter Pack (4 capsules of 0.23mg and 3 capsules of 0.46mg) ☐ Starter Kit (4 capsules of 0.23mg, 3 capsules of 0.46mg, and 1 bottle containing 30 capsules of 0.92mg) ☐ 0.92mg capsules	☐ Take 0.23mg capsule by mouth once daily on days 1-4, then 0.46mg capsule once daily on days 5-7 ☐ Take 0.23mg capsule by mouth once daily on days 1-4, then 0.46mg capsule once daily on days 5-7, then 0.92mg capsule once daily starting on day 8 ☐ Take 0.92mg capsule by mouth once daily	☐ 1 Starter Pack (7-day supply) ☐ 1 Starter Kit (37-day supply) ☐ 30-day supply ☐ 90-day supply	

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

Physician Signature: ______________________ Date: ______________________

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

www.noblehealthservices.com

Important Notice: This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy. Q220222