E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE NEW YORK**
Tel: 888-843-2040
Fax: **888-842-3977**

☐ **NOBLE MISSISSIPPI**
Tel: 866-420-4041
Fax: **601-420-4040**

Inflammatory Bowel Disease

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____
ICD-10 Code: _____
Height: _____ ft _____ inches Weight: _____ lbs
Last PPD Test: ☐ Positive ☐ Negative Date: _____
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®	☐ 200 mg/ml Prefilled SYR ☐ Starter Kit	Loading Dose: ☐ Inject 400 mg SC at weeks 0, 2 and 4	Maintenance Dose: ☐ Inject 200 mg SC every other week ☐ Inject 400 mg SC every 4 weeks	☐ 4 week supply	
Entyvio	☐ 300 mg Vial	Loading Dose: ☐ Inject 300 mg SC at weeks 0, 2, and 4	Maintenance Dose: ☐ Inject 300 mg SC every 8 weeks	☐ 4 week supply ☐ 8 week supply	
Humira® **Citrate-Free**	☐ 40mg/0.4 ml pen ☐ 40 mg/0.4 ml Prefilled SYR	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC once a week ☐ Other		☐ 4 week supply	
Humira® Crohn's Starter Kit/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 80 mg Day 1 and 80mg Day 2 then 80mg on Day 15, maintenance beginning on day 29 ☐ Other		☐ 4 week supply	
Inflectra®	☐ 100 mg vial	Loading Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV at 0, 2 and 6 weeks, then every 8 weeks thereafter ☐ Other	Maintenance Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV every 8 weeks	☐ _____ # of Vials	
Rayos®	☐ 1 mg tablet ☐ 2 mg tablet ☐ 5 mg tablet	☐ Take _____ mg by mouth once per day ☐ Other			

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

Physician Signature: _____ Date: _____

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Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

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CLINICAL INFORMATION

Diagnosis: _____
ICD-10 Code: _____
Height: _____ ft _____ inches Weight: _____ lbs
Last PPD Test: ☐ Positive ☐ Negative Date: _____
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	Loading Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV at 0, 2 and 6 weeks, then every 8 weeks thereafter Maintenance Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV every 8 weeks ☐ Infuse _____ mg via IV every _____ weeks ☐ Other	☐ _____ # of Vials	
Renflexis ®	☐ 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 5mg/kg (Dose _____mg) via IV every 8 weeks ☐ Other	☐ _____ # of Vials	
Simponi®	SmartJect Autoinjector: ☐ 100 mg/1 ml ☐ 50 mg/0.5 ml Prefilled Syringe: ☐ 100 mg/1 ml ☐ 50 mg/0.5ml	☐ Inject 100 mg SC ONCE a month ☐ Inject 50 mg SC ONCE a month ☐ Other	☐ 4 week supply	
Stelara®	☐ 130mg/26ml single dose vial ☐ 90mg/ml Prefilled SYR *(Maintenance dosing only)	Loading Dose: ☐ Infuse _____mg via IV as directed by prescriber Maintenance Dose: ☐ Inject 90mg SC 8 weeks after induction infusion then continue every 8 weeks ☐ Other ***_____Date of initial infusion	☐ 8 week supply	
Xeljanz®	☐ 5mg tablet ☐ 10 mg tablet	☐ Once daily ☐ Twice Daily ☐ Other	☐ 4 week supply	
Other				

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

Physician Signature: _____ Date: _____

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