



INFLAMMATORY BOWEL DISEASE / CROHN'S & COLITIS

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

Patient Name: _____ Male: ☐ Prescriber: _____

Address: _____ Female: ☐ Office Contact: _____

City: _____ State: _____ Zip: _____ Address: _____

Email: _____ City: _____ State: _____ Zip: _____

Last 4 of SSN: _____ DOB: _____ Phone: _____ Fax: _____

Translator: Yes ☐ No ☐ Language: _____ DEA/NPI #: _____

Patient interested in: Support Programs ☐ Ancillary Supplies ☐ Signature: _____ Date: _____

PRESCRIBER INFORMATION

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

CLINICAL INFORMATION

Diagnosis: _____ ICD-10 Code: _____

Has the patient been treated previously for this condition: Yes ☐ No ☐ Height: _____ ft _____ in Weight: _____ lbs

Allergies: _____ Medications On: _____

Other Notes: _____ Medications Failed: _____

AMJEVITA® CITRATE-FREE (HUMIRA BIOSIMILAR)

Dosage/Strength:

- ☐ 20mg/0.4ml prefilled syringe
☐ 40mg/0.8ml prefilled syringe
☐ 40mg/0.8ml prefilled pen

Directions:

- ☐ Inject 40mg every other week
☐ Inject 40mg every week

Quantity:

Refill:

CIMZIA®

Dosage/Strength:

- ☐ 200mg/ml prefilled syringe

Directions:

Loading Dose:

- ☐ Inject 400mg SC at weeks 0, 2, 4

Maintenance Dose:

- ☐ Inject 400mg SC every 4 weeks
☐ Other:

Quantity: ☐ 4-week supply

Refill:

CYLTEZO® CITRATE-FREE (HUMIRA INTERCHANGEABLE BIOSIMILAR)

Dosage/Strength:

- ☐ 20mg/0.4ml prefilled syringe
☐ 40mg/0.8ml prefilled syringe
☐ 40mg/0.8ml prefilled pen

Directions:

- ☐ Inject 40mg every other week
☐ Inject 40mg every week

Quantity:

Refill:

DUPIXENT®

Dosage/Strength:

- ☐ 300mg/2ml single-dose prefilled syringe
☐ 300mg/2ml single-dose prefilled pen

Directions:

- ☐ Inject 300mg subcutaneously every week
(eosinophilic esophagitis)

Quantity: ☐ 30-day supply ☐ 90-day supply

Refill:

ENTVIO®

Dosage/Strength: ☐ 300mg vial

Directions:

Loading Dose:

- ☐ Infuse 300mg via IV at weeks 0, 2, 6

Maintenance Dose:

- ☐ Infuse 300mg via IV every 8 weeks

Quantity: ☐ 4-week supply ☐ 8-week supply

Refill:

HADLIMA® (HUMIRA BIOSIMILAR)

Dosage/Strength:

- ☐ 40mg/0.4ml syringe
☐ 40mg/0.8ml syringe
☐ 40mg/0.4ml Pushtouch syringe
☐ 40mg/0.8ml Pushtouch syringe

Directions:

- ☐ Inject 40mg every other week
☐ Inject 40mg every week

Quantity:

Refill:

HUMIRA® CITRATE-FREE

Dosage/Strength:

- ☐ 40mg/0.4ml pen
☐ 40mg/0.4ml prefilled syringe

Directions:

- ☐ Inject 40mg SC every other week
☐ Inject 40mg SC once a week

Quantity: ☐ 4-week supply

Refill:

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City: _____ State: _____ Zip: _____ Address: _____

Email: _____ City: _____ State: _____ Zip: _____

Last 4 of SSN: _____ DOB: _____ Phone: _____ Fax: _____

Translator: Yes ☐ No ☐ Language: _____ DEA/NPI #: _____

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Allergies: _____ Medications On: _____

Other Notes: _____ Medications Failed: _____

HUMIRA® CITRATE-FREE ADULT CROHN'S/UC/HS

Dosage/Strength: ☐ 80mg/0.8ml pen x3

Directions:

Loading Dose:

- ☐ Inject 160mg SC day 1, 80mg day 15, maintenance beginning on day 29
- ☐ Inject 80mg SC day 1, 80mg day 2, 80mg day 15, maintenance beginning on day 29

Quantity: ☐ 4-week supply

Refill:

HUMIRA® CITRATE-FREE PEDIATRIC CROHN'S DISEASE (AGE 6+/17KG (37LB) TO <40KG (88LB))

Dosage/Strength:

- ☐ 80mg/0.8ml prefilled syringe x1 and 40mg/0.4ml prefilled syringe x1 (Starter Kit)
- ☐ 20mg/0.2ml prefilled syringe x2 (Maintenance)

Directions:

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

Quantity: ☐ 4-week supply

Refill:

HUMIRA® CITRATE-FREE PEDIATRIC CROHN'S DISEASE (AGE 6+/40KG (88LB) AND GREATER)

Dosage/Strength:

- ☐ 80mg/0.8ml pen x4 (Starter Kit)
- ☐ 80mg/0.8ml pen x2 (Maintenance)
- ☐ 40mg/0.4ml pen x2 (Maintenance)
- ☐ 40mg/0.4ml prefilled syringe x2 (Maintenance)

Directions:

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

Quantity: ☐ 4-week supply

Refill:

INFLECTRA®

Dosage/Strength: ☐ 100mg vial

Directions:

Loading Dose:

- ☐ Infuse _____ mg (5mg/kg) at 0, 2, 6 weeks then every 8 weeks thereafter via IV

Maintenance Dose:

- ☐ Infuse _____ mg (5mg/kg) every 8 weeks via IV

- ☐ Other:

Quantity: _____ vials

Refill:

RAYOS®

Dosage/Strength:

- ☐ 1mg tablet ☐ 2mg tablet ☐ 5mg tablet

Directions:

- ☐ Take _____ mg by mouth once per day
- ☐ Other:

Quantity: ☐ _____-day supply

Refill:

REMICADE®

Dosage/Strength: ☐ 100mg vial

Directions:

Loading Dose:

- ☐ Infuse _____ mg (5mg/kg) at 0, 2, 6 weeks, then every 8 weeks thereafter via IV

Maintenance Dose:

- ☐ Infuse _____ (5mg/kg) every 8 weeks via IV
- ☐ Infuse _____ (5mg/kg) every _____ weeks via IV

- ☐ Other:

Quantity: ☐ 4-week supply

Refill:



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Last 4 of SSN: _____ DOB: _____ Phone: _____ Fax: _____

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Other Notes: _____ Medications Failed: _____

RENFLEXIS®

Dosage/Strength: ☐ 100mg vial

Directions:

Loading Dose:

☐ Infuse _____ mg (5mg/kg) at 0, 2, 6 weeks, then every 8 weeks thereafter via IV

Maintenance Dose:

☐ Infuse _____ (5mg/kg) every 8 weeks via IV

☐ Infuse _____ (5mg/kg) every _____ weeks via IV

☐ Other: _____

Quantity: ☐ 4-week supply

Refill:

RINVOQ™

Dosage/Strength:

☐ 15mg tablet ☐ 30mg tablet ☐ 45mg tablet

Directions:

Induction Dose:

☐ Take 1 tab (45mg) by mouth daily for 8 weeks

Maintenance Dose:

☐ Take 1 tab (15mg) by mouth daily

☐ Take 1 tab (30mg) by mouth daily

Quantity:

☐ 28 tablets w/1 refill ☐ 30 tablets

☐ 90 tablets

Refill:

SIMPONI®

Dosage/Strength:

Prefilled Syringe:

☐ 50mg/0.5ml ☐ 100mg/1ml

SmartJect Autoinjector:

☐ 50mg/0.5ml ☐ 100mg/1ml

Directions:

☐ Inject 50 mg SC once a month

☐ Inject 100 mg SC once a month

☐ Inject 200mg SC at week 0, 100mg at week 2 then 100mg every 4 weeks thereafter

☐ Other

Quantity: ☐ 4-week supply

Refill:

SKYRIZI®

Dosage/Strength:

☐ 600mg/10ml vial

☐ 180mg/1.2ml single-use on-body injector

☐ 360mg/2.4ml single-use on-body injector

Directions:

New Patient Infusion:

☐ Infuse 600mg IV at weeks 0, 4, 8

New Patient Maintenance:

☐ Inject 180mg SC at week 12 and every 8 weeks thereafter

☐ Inject 360mg SC at week 12 and every 8 weeks thereafter

Existing Patient Maintenance:

☐ Inject 180mg SC every 8 weeks

☐ Inject 360mg SC every 8 weeks

Quantity: ☐ 8-week supply

Refill:

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Allergies: _____ Medications On: _____

Other Notes: _____ Medications Failed: _____

STELARA®

Date of Initial Infusion: _____

Dosage/Strength:

- ☐ 130/26ml single dose vial
☐ 90mg/ml prefilled syringe (Maintenance)

Directions:

Loading Dose:

- ☐ Infuse _____ mg IV as directed by the prescriber

Maintenance Dose:

- ☐ Inject 90mg SC 8 weeks after induction infusion, then continue every 8 weeks
☐ Other

Quantity: ☐ 8-week supply

Refill: _____

XELJANZ®

Dosage/Strength:

- ☐ 5mg tablet ☐ 10mg tablet

Directions:

- ☐ Take one tablet twice a day
☐ Take one tablet once a day
☐ Other

Quantity:

- ☐ 30-day supply ☐ 90-day supply

Refill: _____

XELJANZ® XR

Dosage/Strength:

- ☐ 11mg tablet ☐ 22mg tablet

Directions:

- ☐ Take one tablet twice a day
☐ Take one tablet once a day
☐ Other

Quantity:

- ☐ 30-day supply ☐ 90-day supply

Refill: _____

ZEPOSIA®

Dosage/Strength:

- ☐ 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

Directions:

- ☐ 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

Quantity:

- ☐ 1 Starter Pack (7-day supply)
☐ 1 Starter Kit (37-day supply)
☐ 30-day supply ☐ 90-day supply

Refill: _____

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