



# IBD/CROHN'S & COLITIS E-SCRIBE and FAX ENROLLMENT FORM

- NOBLE NORTHEAST: E-Scribe: NOBLE | Fax: 888-842-3977 | Tel: 888-843-2040
- NOBLE CAROLINAS: E-Scribe: NOBLE | Fax: 888-842-3977 | Tel: 888-743-3204
- 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

## PRESCRIBER INFORMATION

Patient Name: \_\_\_\_\_ Male:  Prescriber: \_\_\_\_\_  
 Address: \_\_\_\_\_ Female:  Office Contact: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ 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: \_\_\_\_\_

## 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: \_\_\_\_\_

## MEDICATION INFORMATION

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Amjevita® Citrate-free (Humira Biosimilar)<br><input type="checkbox"/> Cimzia®<br><input type="checkbox"/> Cyltezo® Citrate-free (Humira Interchangeable Biosimilar)<br><input type="checkbox"/> Dupixent®<br><input type="checkbox"/> Entyvio®<br><input type="checkbox"/> Hadlima® (Humira Biosimilar)<br><input type="checkbox"/> Humira® Citrate-free<br><input type="checkbox"/> Humira® Citrate-free Adult Crohn's/UC/HS<br><input type="checkbox"/> Humira® Citrate-free Pediatric Crohn's Disease (Age 6+/17kg (37lb) to <40kg (88lb)) | <input type="checkbox"/> Humira® Citrate-free Pediatric Crohn's Disease (Age 6+/40kg (88lb) and greater)<br><input type="checkbox"/> Hyrimoz® (Humira Biosimilar)<br><input type="checkbox"/> Inflectra®<br><input type="checkbox"/> Omvoh™<br><input type="checkbox"/> Rayos®<br><input type="checkbox"/> Remicade®<br><input type="checkbox"/> Renflexis®<br><input type="checkbox"/> Rinvoq®<br><input type="checkbox"/> Simponi®<br><input type="checkbox"/> Skyrizi® | <input type="checkbox"/> Stelara®<br><input type="checkbox"/> Xeljanz®<br><input type="checkbox"/> Xeljanz XR®<br><input type="checkbox"/> Yuflyma® (Humira Biosimilar)<br><input type="checkbox"/> Zeposia®<br><input type="checkbox"/> Zymfentra™<br><input type="checkbox"/> Other: _____ |
|---|---|--|

Dosage/Strength:	Route of Administration:	Directions:	Quantity:	Refills:	Dispense as Written:
	<input type="checkbox"/> Pen <input type="checkbox"/> Starter Kit <input type="checkbox"/> Syringe <input type="checkbox"/> Tablet <input type="checkbox"/> Topical <input type="checkbox"/> Vial				

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