Inflammatory Bowel Disease Enrollment Form A-M

www.noblehealthservices.com

NOBLE HEALTH SERVICES
A SPECIALTY PHARMACY
Signature Care Program

☐ **Noble Syracuse**
Phone: (888) 843-2040
Fax: (888) 842-3977
☐ **Noble Mississippi**
Phone: (866) 420-4041
Fax: (601) 420-4040

Delivery Need By: Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis/ ICD-10 Code: ☐ K50.00 ☐ K50.019 ☐ K50.118 ☐ K50.80 ☐ K50.018 ☐ K50.10 ☐ K50.119 ☐ K50.818 ☐ Other	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Last PPD Test ☐ Positive ☐ Negative Date: D/M/Y / /	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Cimzia®	☐ Starter Kit ☐ 200 mg/ml Prefilled SYR	☐ Initial Dose Inject 400mg SC at weeks 0,2, and 4, then: Maintenance Dose: ☐ 200mg SC every other week OR ☐ 400mg SC every 4 weeks	☐ 4 week supply	
Entyvio®	☐ 300mg Vial	☐ Initial Dose Inject 300mg SC at weeks 0,2, and 4 ☐ Maintenance Dose: 300mg SC every 8 weeks ☐ Other:	☐ 4 week supply ☐ 8 week supply ☐ Other:	
Humira®	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled SYR ☐ 40mg/0.4ml Pen **(Citrate-Free)** ☐ 40mg/0.4ml Prefilled SYR **(Citrate-Free)**	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	☐ 4 week supply ☐ Other:	
Humira® Crohn's Starter Kit/UC/HS	☐ 40mg/0.8ml Pen x6 (Starter Kit) ☐ 80mg/0.8ml Pen x3 (Starter Kit) (Citrate-Free)	☐ Inject 160mg SC Day 1 and 80mg on Day 15, maintenance beginning on day 29 OR ☐ Inject 80 mg Day 1 and 80mg Day 2 then 80mg on Day 15, maintenance beginning on day 29	☐ Initial 4 week supply	

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

Office Contact Name: __________________________ Preferred Phone Number & Extension: __________________________

Physician Signature: __________________________ Date: ____________

E-Scribe Rx and Fax this Form

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.*

Inflammatory Bowel Disease Enrollment Form N-Z

www.noblehealthservices.com

Signature Care Program

☐ **Noble Syracuse**
Phone: (888) 843-2040
Fax: (888) 842-3977
☐ **Noble Mississippi**
Phone: (866) 420-4041
Fax: (601) 420-4040

Delivery Need By: Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis/ ICD-10 Code: ☐ K50.00 ☐ K50.019 ☐ K50.118 ☐ K50.80 ☐ K50.018 ☐ K50.10 ☐ K50.119 ☐ K50.818 ☐ Other	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Last PPD Test D/M/Y ☐ Positive ☐ Negative Date: / /	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Remicade®	☐ 100mg Vial	☐ IV mg at 0, 2, and 6 weeks (induction) ☐ IV mg every 8 weeks (maintenance) ☐ IV mg every weeks	# of vials	
Simponi®	☐ 100mg/1ml SmartJect AutoInjector ☐ 100mg/1ml Prefilled SYR	Inject 100mg SC ONCE a month	☐ 4 week supply ☐ Other:	
Stelara® Crohn's	☐ 90mg/ml Prefilled SYR *(Maintenance dosing only)	☐ Inject 90mg SC 8 weeks after infusion then continue every 8 weeks	☐ 16 week supply ☐ Other:	
Xeljanz®	☐ 5mg ☐ 10mg	☐ Twice Daily ☐ Once Daily	☐	
Other:				

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

Office Contact Name: ___________________________ Preferred Phone Number & Extension: ___________________________

Physician Signature: ___________________________ Date: _____________

E-Scribe Rx and Fax this Form

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.*