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 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:
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

Inflammatory Bowel Disease Enrollment Form N-Z

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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#:

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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:
Inflectra®	☐ 100 mg VIAL	☐Induction Dose: 5mg/kg (Dose _____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter ☐ Maintenance Dose: 5mg/kg (Dose _____mg) IV every 8 weeks	# of vials	
Remicade®	☐ 100mg VIAL	☐Induction Dose: 5mg/kg (Dose _____mg) IV at 0, 2, and 6 weeks (~~induction~~) then every 8 weeks thereafter ☐Maintenance Dose: 5mg/kg (Dose _____mg) IV every 8 weeks (~~maintenance~~) ☐ IV mg every weeks	# of vials	
Renflexis ™	☐ 100mg VIAL	☐ Induction Dose: 5mg/kg (Dose_____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter. ☐ Maintenance Dose: 5mg/kg (Dose _____mg) IV every 8 weeks	# of vials	
Simponi®	☐ 100mg/1ml SmartJect AutoInjector ☐ 100mg/1ml Prefilled SYR	Inject 100mg SC ONCE a month	☐ 4 week supply ☐ Other:	
Stelara®	☐ 130mg/26ml single dose vial	☐Induction dose: Infuse _____mg IV as directed by prescriber	# of vials	
Stelara ®	☐ 90mg/ml Prefilled SYR *(Maintenance dosing only)	☐ Inject 90mg SC 8 weeks after induction infusion then continue every 8 weeks ***_____Date of initial infusion	☐ 8 week supply ☐ Other:	
Xeljanz®	☐ 5mg ☐ 10mg	☐ Twice Daily ☐ Once Daily		
Other:			☐ tablets	
☐ 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