



# 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

## 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

Amjevita® Citrate-free (Humira Biosimilar)

Cimzia®

Cyltezo® Citrate-free (Humira Interchangeable Biosimilar)

Dupixent®

Entyvio®

Hadlima® (Humira Biosimilar)

Humira® Citrate-free

Humira® Citrate-free Adult Crohn's/UC/HS

Humira® Citrate-free Pediatric Crohn's Disease (Age 6+/17kg (37lb) to <40kg (88lb))

Humira® Citrate-free Pediatric Crohn's Disease (Age 6+/40kg (88lb) and greater)

Hyrimoz® (Humira Biosimilar)

Inflectra®

Rayos®

Remicade®

Renflexis®

Rinvoq®

Simponi®

Skyrizi®

Stelara®

Xeljanz®

Xeljanz XR®

Yuflyma® (Humira Biosimilar)

Zeposia®

Zymfentra™

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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