NOBLE HEALTH SERVICES

ASTHMA AND ALLERGY
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	PROVIDER INFORMATION
Patient Name: _____ ☐ Male	Prescriber's Name: _____
Street Address: _____ ☐ Female	Office Contact Name: _____
City: _____ State: _____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: _____ Zip Code: _____
Email Address: _____	Phone Number: _____
Last Four of Social: _____ Date of Birth: _____	Fax Number: _____
Translator Needed: ☐ Yes ☐ No Language: _____	DEA/NPI #: _____

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

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Cinqair®	☐ 100mg/10ml vial	☐ Infuse _____ mg (3mg/kg) via IV Infusion every 4 weeks	☐ _____ vials ☐ 30-day supply ☐ 90-day supply	
Dupixent®	☐ 200mg/1.14ml single-dose pre-filled syringe ☐ 300mg/2ml single-dose pre-filled syringe ☐ 300mg/2ml single-dose pre-filled PEN	Loading Dose: ☐ Inject 400mg (two 200mg injections) subcutaneiously on day 1 ☐ Inject 600 mg (two 300 mg injections) subcutaneously on day 1 Maintenance Dose: ☐ Inject 200 mg every other week ☐ Inject 300 mg every other week	☐ 30-day supply ☐ 90-day supply	
Xolair®	☐ 75mg/0.5ml single-dose prefilled syringe ☐ 150mg/ml single dose prefilled syringe ☐ 150mg powder for injection	☐ Inject _____ mg every 2 weeks ☐ Inject _____ mg every 4 weeks ☐ Other	☐ 30-day supply ☐ 90-day supply	
Other				

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

Physician Signature: _____ Date: _____

NATIONALLY ACCREDITED. **100% EMPLOYEE OWNED.**

www.noblehealthservices.com