NOBLE HEALTH SERVICES

NEUROLOGY
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:
Aubagio®	☐ 7mg ☐ 14mg	☐ Take one tablet once a day ☐ Other	☐ 28-day supply	
Austedo® deutetrabenazine	☐ 6mg tablet ☐ 9mg tablet ☐ 12mg tablet	☐ _____ mg by mouth once daily ☐ _____ mg by mouth twice daily ☐ Other	☐ 7-day supply ☐ 30-day supply	
Avonex®	☐ 30mcg vial ☐ 30mcg syringe ☐ 30mcg pen	☐ Inject 30mcg intramuscularly once a week	☐ 30-day supply	
Betaseron®	☐ 0.3mg vial	☐ Inject .25mg (1ml) SC every other day ☐ Other	☐ 28-day supply	
Botox®	☐ 100U ☐ 200U	☐ Inject ____ units as directed	☐ _____ vials	
Copaxone®	☐ 20mg/ml ☐ 40mg/ml	☐ Inject 20mg SC daily ☐ Inject 40mg SC three times a week ☐ Other	☐ ____-day supply	
dalfampridine	☐ 10mg extended-release tablet	☐ Take one tablet twice daily every 12 hours ☐ Other	☐ 30-day supply	
Elaprase®	☐ 6mg/3ml	☐ Specified:		
Extavia	☐ 0.3mg single-dose vial	☐ Inject .25mg (1ml) SC every other day ☐ Other	☐ 28-day supply	

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

Physician Signature: _____ Date: _____

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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 #: _____

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Allergies: _____

Other Notes: _____

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Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Gilenya®	☐ 0.5mg tablet	☐ Take one capsule once a day ☐ Other	☐ 30-day supply	
glatiramer acetate injection	☐ 20mg/ml prefilled syringe ☐ 40mg/ml prefilled syringe	☐ Inject 20mg/ml (1 syringe) SC once a day ☐ Inject 40mg/ml (1 syringe) SC three times a week and at least 48 hours apart ☐ Other	☐ ____ prefilled syringes	
Glatopa®	☐ 20mg/ml prefilled syringe ☐ 40mg/ml prefilled syringe	☐ Inject 20mg/ml (1 syringe) SC once a day ☐ Inject 40mg/ml (1 syringe) SC three times a week and at least 48 hours apart ☐ Other	☐ ____ prefilled syringes	
Kesimpta®	☐ 20mg/0.4ml prefilled pen	Loading Dose: ☐ Inject 20mg SC at weeks 0,1,2 Maintenance Dose: ☐ Inject 20mg SC monthly starting at week 4	☐ ____-day supply	
Mayzent®	☐ 0.25mg tablet ☐ 2 mg tablet	☐ Take ___ mg by mouth daily ☐ Other	☐ ____-day supply	
Novantrone	☐ 20mg/10mL ☐ 25mg/12.5mL ☐ 30mg/15mL	☐ _____ mg (12 mg/m^2) IV every 3 months ☐ Other		
Plegridy®	☐ Starter Pack (63mcg and 94mcg) Prefilled Syringes ☐ Starter Pack (63mcg and 94mcg) Autoinjectors ☐ 125mcg/0.5ml prefilled syringe ☐ 125mcg/0.5ml autoinjector	Loading Dose: ☐ Inject 63 mcg SC once on day 1, inject 94mcg SC on day 15, then inject 125mcg SC on day 29 and every 2 weeks thereafter Maintenance Dose: ☐ Inject 125mcg SC every 2 weeks		

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

Physician Signature: _____ Date: _____

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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: _____
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ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Rebif®	☐ 22 mcg prefilled syringe ☐ 44 mcg prefilled syringe	☐ Inject _____ mcg SC three times a week ☐ Other		
Rebif® Rebidose	☐ 44 mcg/0.5ml prefiled syringe	☐ Inject 44mcg subcuteanously three times a week ☐ Other		
Rebif® Rebidose Titration	☐ 8.8mcg/0.2ml-22mcg/0.5ml	☐ Titration Schedule: **Weeks 1-2**: 4.4mcg (0.1ml) SC three times a week **Weeks 3-4:** 11mcg (0.25ml) SC three times a week **Week 5+:** 22mcg (.5ml) SC three times a week ☐ Titration Schedule: **Week 1-2:** 8.8mcg (0.1ml) SC three times a week **Week 3-4:** 22mcg (0.25ml) SC three times a week **Week 5+:** 44mcg (.5ml) SC three times a week ☐ Other	☐ 30-day supply	
Rebif® Syringe Titration	☐ 8.8mcg/0.2ml-22mcg/0.5ml	☐ Titration Schedule: **Weeks 1-2**: 4.4mcg (0.1ml) SC three times a week **Weeks 3-4:** 11mcg (0.25ml) SC three times a week **Week 5+:** 22mcg (.5ml) SC three times a week ☐ Titration Schedule: **Week 1-2:** 8.8mcg (0.1ml) SC three times a week **Week 3-4:** 22mcg (0.25ml) SC three times a week **Week 5+:** 44mcg (.5ml) SC three times a week ☐ Other		

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Physician Signature: _____ Date: _____

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City: _____ State: ____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: ____ Zip Code: _____
Email Address: _____	Phone Number: _____
Last Four of Social: _____ Date of Birth: _____	Fax Number: _____
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CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Tecfidera® dimethyl fumarate ***Generic Only***	☐ 120mg delayed-release capsule ☐ 240mg delayed-release capsule	☐ Take 120mg by mouth twice daily for seven days ☐ Take 240mg by mouth twice daily ☐ Other	☐ 14 capsules ☐ ____-day supply	
Xenazine® tetrabenazine ***Generic Only***	☐ 12.5mg tablet ☐ 25mg tablet	☐ _____ mg by mouth once daily ☐ _____ mg by mouth twice daily ☐ Other	☐ 7-day supply ☐ 30-day supply	
vigabatrin	☐ 500mg packet - powder for solution formulation only	☐ _____ mg by mouth twice a day	☐ _____ packets	
Zeposia®	☐ 7-Day Starter Pack: (4) 0.23mg capsules and (3) 0.46mg capsules ☐ 37-Day Starter Kit: (1)7Day starter pack and (1) bottle of 30 0.92mg capsules ☐ 0.92 mg capsules	☐ Starting Dose: Days 1-4: Take 0.23 mg capsule by mouth 1 time a day Days 5-7: Take 0.46 mg capsule by mouth 1 time a day ☐ Maintenance Dose: Take 0.92mg capsule by mouth once daily	☐ 7-Day Starter Pack ☐ 37- Starter Kit (includes 30-days maintenance) ☐ 30-day supply (maintenance) ☐ Other	
Other				

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Physician Signature: _____ Date: _____

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