NOBLE HEALTH SERVICES

CARDIOLOGY

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: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Medications Failed: _____

Medications On: _____

Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Adcirca	☐ 20mg tablets	☐ Take 40mg by mouth once daily ☐ Other	☐ 30-day supply	
Ambrisentan	☐ 5mg tablet ☐ 10mg tablet	☐ Take 5mg by mouth once daily ☐ Take 10mg by mouth once daily ☐ Other	☐ 30-day supply	
Bosentan	☐ 62.5mg film-coated tablet ☐ 125mg film-coated tablet ☐ 32mg tablet for oral suspension	☐ Take 62.5mg by mouth twice daily ☐ Take 125mg by mouth twice daily ☐ Other	☐ 30-day supply	
Entresto®	☐ 24/26 mg tablet ☐ 49/51 mg tablet ☐ 97/103 mg tablet	☐ Take 24/26mg tablet by mouth twice daily ☐ Take 49/51mg tablet by mouth twice daily ☐ Take 97/103mg tablet by mouth twice daily ☐ Other	☐ 14-day supply ☐ 30-day supply	
Praluent®	☐ Injection Single Dose Pen 75mg/ml ☐ Injection Single-Dose Pen 150mg/ml	☐ Inject 75mg subcutaneously every 2 weeks ☐ Inject 150mg subcutaneously every 2 weeks ☐ Other	☐ 4-week supply	

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

Physician Signature: _____ Date: _____

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

www.noblehealthservices.com

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Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Repatha®	☐ Prefilled Syringe 140mg/ml ☐ SureClick Autoinjector 140mg/ml ☐ PushTronex (onbody infuser with prefilled cartridge) 420mg/3.5ml	Pen/Syringe: ☐ Inject 140mg subcutaneously every 2 weeks ☐ Other PushTronex: ☐ Inject 420mg subcutaneiously (using device) once monthly ☐ Other	☐ 4-week supply	
Revatio®	☐ 20mg tablet ☐ 10mg/12.5 ml vial solution for injection ☐ 10mg/ml for oral suspension	☐ Take 20mg by mouth 3 times daily ☐ Other	☐ 30-day supply ☐ Other	
Tikosyn®	☐ 125mcg ☐ 250mcg ☐ 500mcg	☐ Specified	☐ 30-day supply ☐ Other	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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