

DERMATOLOGY

E-SCRIBE and FAX ENROLLMENT FORM

NOBLE NORTHEAST: E-Scribe: NOBLE | Fax: 888-842-3977 | Tel: 888-843-2040

Delivery Needed By: D	eliver to: 🗌 Patient's H	ome 🗌 Physician's C	Office			
PATIENT INFORMA	TION	PRES	CRIBER INFORMATION			
Patient Name:	Male:	Prescriber:				
Address:	_	Office Contact:				
City: State:						
Email:			State:Zip:			
Last 4 of SSN: DOB:			Fax:			
Translator: Yes \(\bigcap \) No \(\bigcap \) Languag						
			Date:			
INSURANCE INFORMATION -			SACK OF PRESCRIPTION CARD			
	CLINICAL IN	IFORMATION				
Diagnosis:		ICD-10 Code:				
Has the patient been treated previously	for this condition: Yes [No Height:	ftin Weight: lbs			
Allergies:		Medications On:				
Other Notes:		Medications Failed:				
ACTEMRA®	AMJEVITA® CITRATE-FF	REE	CIMZIA®			
Dosage/Strength:	HUMIRA BIOSIMILAR) Dosage/Strength: 20mg/0.4ml prefilled syringe 40mg/0.8ml prefilled syringe 40mg/0.8ml prefilled pen		Dosage/Strength: ☐ 200mg/ml prefilled syringe ☐ Starter Kit Directions:			
☐ 162mg/0.9ml prefilled syringe ☐ 162mg/0.9ml ACTPen autoinjector						
Directions:			Loading Dose:			
☐ Inject SC every other week ☐ Inject SC every week	Directions:		☐ Inject 400mg SC at weeks 0, 2, 4 Maintenance Dose:			
Other:	☐ Inject 40mg every ot		☐ Inject 200mg SC every other week			
Quantity: 4-week supply	Inject 40mg every we	eek	(option for patients <90kg body weight) ☐ Inject 400mg SC every 4 weeks			
Refill:	Quantity:		Other:			
ADBRY®	Refill:		Quantity: 4-week supply			
Dosage/Strength:	вотох		Refill:			
150mg/ml prefilled syringe	Dosage/Strength: 100U Vial □ 200U V	/ial	COSENTYX®			
Directions:	Directions:	/lal	Dosage/Strength:			
Initial Loading Dose: Inject 600mg (4 - 150mg injections) SC on day 1		very weeks	☐ 75mg syringe ☐ 150mg pen			
Maintenance Dose:	Quantity:		☐ 150mg syringe			
☐ Inject 300mg (2 - 150mg) SC every 2 weeks	Refill:		Directions:			
Maintenance Dose option for patients weighing <100kg, stable on Adbry >16 weeks with clear or	CIBINQO®		Loading Dose: ☐ Inject 150mg at weeks 0, 1, 2, 3, 4			
almost clear skin:	Dosage/Strength:		☐ Inject 300mg at weeks 0, 1, 2, 3, 4			
Inject 300mg (2 - 150mg) SC every 4 weeks		mg tablet	Maintenance Dose:			
Quantity: 4-week supply	200mg tablet		☐ Inject 150mg every 4 weeks ☐ Inject 300mg every 4 weeks			
Refill:	Directions:		Quantity:			
	1 tablet by mouth once		5-week supply (Loading)			
	Quantity: 30-day supp	oly 90-day supply	4-week supply (Maintenance)			
	Refill:		Pofill:			



☐ Inject 200mg SC every 4 weeks

☐ Inject 300mg SC every 4 weeks

Maintenance Dose:

Body Weight 15kg to <30kg Loading &

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E-Scribe: **NOBLEMS/TRANSCRIPT** | Fax: **601-420-4040** | Tel: 866-420-4041 **□** NOBLE SOUTHEAST: Delivery Needed By:______ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other: _ **PATIENT INFORMATION** PRESCRIBER INFORMATION _____Male: Prescriber: Patient Name: Address: _____ State: _____Zip: _____ Address: ____ _____ City: _____ State: ____Zip: ____ Email: Last 4 of SSN: _____ DOB: ____ Phone: _____ Fax: _____ DEA/NPI #: ____ Translator: Yes ☐ No ☐ Language: Patient interested in: Support Programs ☐ Ancillary Supplies ☐ Signature: INSURANCE INFORMATION - PLEASE FAX A COPY OF FRONT & BACK OF PRESCRIPTION CARD **CLINICAL INFORMATION** ICD-10 Code: Diagnosis: Has the patient been treated previously for this condition: Yes No No Height:_____ ft____in Weight:_____ lbs ______ Medications On: ______ Allergies: __ Other Notes: Medications Failed: **DUOBRIL®** ENBREL® AND ENBREL® MINI Pediatric Patients 6 years to 17 years of age Body Weight 15kg to <30kg Loading Dose: Dosage/Strength: 0.01%/0.045% lotion Dosage/Strength: ☐ Inject 600mg (2-300mg injections) SC on day 1 ☐ 25ma/0.5ml prefilled syringe Directions: Body Weight 15kg to <30kg Maintenance Dose: ☐ 50mg/ml single-use prefilled syringe Apply a thin layer of lotion topically to the ☐ Inject 200mg SC every 4 weeks ☐ 50mg/ml SureClick autoinjector affected area(s) once daily ☐ Inject 300mg SC every 4 weeks Quantity: 100 gram tube Body Weight 30kg to <60kg Loading Dose: ☐ 50mg Enbrel® Mini single-dose prefilled Refill: ☐ Inject 400mg (2-200mg injections) SC on day 1 cartridge Body Weight 30kg to <60kg Maintenance Dose: **DUPIXENT®** ☐ Inject 200mg SC every 2 weeks ☐ Inject 25mg SC twice a week (72-96 hrs apart) Dosage/Strength: Body Weight 60kg or more Loading Dose: ☐ Inject 50mg SC twice a week (72-96 hrs apart) 200mg/1.14ml single-dose prefilled syringe ☐ Inject 600mg (2-300mg injections) SC on day 1 ☐ Inject 50mg SC once a week 200mg/1.14ml single-dose prefilled pen Body Weight 60kg or more Maintenance Dose: Other: ☐ 300mg/2ml single-dose prefilled syringe ☐ Inject 300mg SC every 2 weeks Quantity: 4-week supply 300mg/2ml single-dose prefilled pen Quantity: 4-week supply Prefilled pens are approved for use in patients Refill: 2 years of age and older. HADLIMA® (HUMIRA BIOSIMILAR) CYLTEZO® CITRATE-FREE (HUMIRA INTERCHANGEABLE BIOSIMILAR) Dosage/Strength: Adult (and Pediatric Patients >60 Kg) 40mg/0.4ml syringe Initial Loading Dose: Dosage/Strength: 40mg/0.8ml syringe ☐ Inject 600mg (2-300mg injections) SC on day 1 ☐ 20mg/0.4ml prefilled syringe ☐ 40mg/0.4ml Pushtouch syringe ☐ 40mg/0.8ml prefilled syringe Maintenance Dose: ☐ 40mg/0.8ml Pushtouch syringe ☐ Inject 300mg SC every 2 weeks 40mg/0.8ml prefilled pen Directions: Pediatric Patients 6 months to 5 years of age Directions: ☐ Inject 40mg every other week Body Weight 5kg to <15kg Loading & ☐ Inject 40mg every other week ☐ Inject 40mg every week Maintenance Dose:

Quantity:

Refill:

☐ Inject 40mg every week

Quantity:

Refill:



Refill:

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Delivery Needed By:	_ Deliver to: Patient's Ho	ome 🗌 Physician's	Office Other:			
PATIENT INFO	RMATION	PRE	SCRIBER INFORMATION			
Patient Name: Address: City: Email:	Female: Zip:	Office Contact:	State: Zip:			
Last 4 of SSN: DC Translator: Yes No La Patient interested in: Support Progra	DB:nguage: ms	Phone: DEA/NPI #: Signature:	Fax: Date: Date:			
MOORANGE IN ORNA		FORMATION	DACK OF TRESORIE FISH CARD			
Has the patient been treated previo	ously for this condition: Yes [No Height	::ftin Weight:lbs			
HUMIRA® CITRATE-FREE	ILUMYA®		OPZELURA™			
Dosage/Strength: 40mg/0.4ml pen 40mg/0.4ml prefilled syringe Directions: Inject 40mg SC every other week Inject 40mg SC once a week	Dosage/Strength: 100mg/ml single-dose Directions: Inject 100mg SC at we weeks thereafter Quantity: 4-week supp	eks 0,4, and every 12	Dosage/Strength: ☐ 1.5% topical cream Directions: ☐ Apply a thin layer topically twice daily to affected areas of up to 20% of body surface area. Do not use more than one 60 gram tube per week or one 100 gram tube every 2 weeks.			
Quantity: 4-week supply	Refill:		Quantity: 60 gram tube 100 gram tube			
Refill: HUMIRA® CITRATE-FREE HS STARTER KIT Dosage/Strength: 80mg/0.8ml pen x3 Directions: Loading Dose: Inject 160mg SC day 1, 80mg day 15, maintenance beginning on day 29 Inject 80mg SC day 1, 80mg day 2, 80mg	Directions: Loading Dose: Infuse mg (5n then every 8 weeks the Maintenance Dose:	ng/kg) at 0, 2, 6 weeks	Refill: OTEZLA® Dosage/Strength: 28-day starter pack titration			
maintenance beginning on day 29	via IV Quantity: vials	,,	Quantity:			
Quantity: 4-week supply Refill:	Refill:		Starter Kit Bottle of 60			
HUMIRA® CITRATE-FREE PSORIASIS/UVE STARTER KIT Dosage/Strength: 80mg/0.8ml pen	Dosage/Strength: 2mg pirections: 1 tablet by Quantity: Refill:		-			
Quantity: 4-week supply						



Refill:

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■ NOBLE SOUTHEAST: E-Scribe: NOBLEMS/TRANSCRIPT | Fax: 601-420-4040 | Tel: 866-420-4041

Delivery Needed By:	Deliver to: 🗌 Patient's Ho	ome Physician's (Office Other:			
PATIENT IN	FORMATION	PRES	SCRIBER INFORMATION			
Patient Name:	Male:	Prescriber:				
Address:	Female:	Office Contact:				
			State:Zip:			
	DOB:					
			Fax:			
	Language:					
Patient interested in: Support Pro	ograms Ancillary Supplies	Signature:	Date:			
INSURANCE INFORM	ATION - PLEASE FAX A CO	PY OF FRONT & I	BACK OF PRESCRIPTION CARD			
	CLINICAL IN	IFORMATION				
Diagnosis:		ICD-10 Code:				
Has the patient been treated p	reviously for this condition: Yes [No Height:	:ftin Weight: lbs			
Allergies		Medications On:				
Other Notes.		Medications Falled:				
OTREXUP®	RAYOS®		RENFLEXIS®			
Dosage/Strength:	Dosage/Strength:		Dosage/Strength: ☐ 100mg vial			
10mg/0.4ml autoinjector	☐ 1mg tablet ☐ 2mg ta	ablet	Directions:			
12.5mg/0.4ml autoinjector	Directions:		Loading Dose:			
15mg/0.4ml autoinjector	Take mg by n	nouth once per day	5mg/kg (Dose mg) IV at weeks 0, 2, 6			
17.5mg/0.4ml autoinjector	Other:		then every 8 weeks thereafter			
20mg/0.4ml autoinjector 22.5mg/0.4ml autoinjector	Quantity: 🔲day	y supply	Maintenance Dose:			
25mg/0.4ml autoinjector	Refill:		☐ 5mg/kg (Dose mg) IV every 8 weeks☐ IV every weeks			
Directions:	REMICADE®		Other:			
☐ Inject mg SC once weekly	Dosage/Strength: ☐ 100	ma vial	Quantity: vials			
Other:		Tilg viai	Refill:			
Quantity: 4-week supply	Directions: <u>Loading Dose:</u>		RINVOQ™			
Refill:	☐ Infuse mg (5		Dosage/Strength: ☐ 15mg tablet ☐ 30mg tabl			
RASUVO®	then every 8 weeks the Maintenance Dose:	ereafter via IV	Directions: ☐ Take one tablet by mouth once daily			
Dosage/Strength:	Infuse (5mg/	kg) every 8 weeks via IV	Quantity: 30-day supply			
7.5mg/0.15ml autoinjector	☐ Infuse (5mg/	kg) every weeks	Refill:			
☐ 10mg/0.2ml autoinjector ☐ 12.5mg/0.25ml autoinjector	via IV □ Other:					
15mg/.3ml autoinjector		lc .	SILIQ™			
☐ 17.5mg/0.35ml autoinjector	Quantity: vial	15	Dosage/Strength: 210mg/1.5ml prefilled syringe			
20mg/0.4ml autoinjector	Refill.					
22.5mg/0.45ml autoinjector			Directions: ☐ Inject 210mg SC at weeks 0, 1, 2 and 210mg SC			
☐ 25mg/0.5ml autoinjector ☐ 27.5mg/0.55ml autoinjector			every 2 weeks thereafter			
30mg/0.6ml autoinjector			Quantity:			
Directions:			Starter Dose (3 syringes)			
☐ Inject mg SC once weekly			Maintenance Dose (2 syringes)			
Other:			Refill:			
Quantity: 4-week supply						

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Delivery Needed By:	Deliver to: Patient's H	ome 🗌 Physician's (Office Other:			
PATIENT INFO	DRMATION	PRES	CRIBER INFORMATION			
	Female: tate:Zip: OB: anguage: cams	Office Contact: Address: City: Phone: DEA/NPI #: Signature:	State:Zip: Fax:Date:			
Has the patient been treated prev	iously for this condition: Yes [No Height:	ftin Weight: lbs			
Dosage/Strength: 50mg/0.5ml prefilled syringe 100mg/1ml prefilled syringe 50mg/0.5ml SmartJect autoinjector 100mg/1ml SmartJect autoinjector Directions: Inject 50mg SC once a month Inject 100mg SC once a month	Dosage/Strength: 45mg/0.5ml prefilled syring 90mg/ml prefilled syring Directions: Patients weighing <100kg Inject 45mg SC at 0 ar weeks thereafter Maintenance Dose: Week 2 Inject 90mg SC at 0 ar	nge <u>I:</u> ad 4 weeks, then every 12	TALTZ® Dosage/Strength:			
then 100mg every 4 weeks thereafter Quantity: 4-week supply Refill: SKYRIZI® Dosage/Strength: 150mg/mL prefilled syringe 150mg/mL pen	weeks thereafter Quantity: 2 syringes (Loading) 1 syringe (Maintenance) Refill: SOTYKYU® Dosage/Strength: 6mg		Quantity: 3 syringes/pens 2 syringes/pens 1 syringe/pen Refill: TREMFYA® Dosage/Strength: 100mg/ml prefilled syringe			
Directions: Loading Dose: ☐ Inject 150mg SC at weeks 0, 4, and eve weeks thereafter Maintenance Dose: ☐ Inject 150mg SC every 12 weeks Quantity: ☐ 1 prefilled syringe/pen Refill:	Directions: Take 1 tablet (6mg) by Quantity: 30-day supp Refill:		□ 100mg/ml prefilled autoinjector Directions: Loading Dose: □ Inject 100mg SC at weeks 0, 4, and every 8 weeks thereafter Maintenance Dose: □ Inject 100mg SC every 8 weeks Guantity: □ 4 week supply (Loading) □ 8 week supply (Maintenance) Refill:			



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Delivery Needed By:	Deliver	to: Patient's H	ome Phys	sician's Office	Othe	er:		
PATIENT IN	IFORMATION	N		PRESCRI	BER INF	ORM	1ATION	
Patient Name:		Male:	Prescriber:_					
Address:		Female:	Office Conta	act:				
City:	_ State:	Zip:	Address:					
Email:			City:		Sta	te: _	Zip:	
Last 4 of SSN:	_ DOB:		Phone:		Fax	c:		
Translator: Yes 📗 No 📗	Language:		DEA/NPI #:					
Patient interested in: Support Pr	ograms 🗌 And	cillary Supplies 🗌	Signature: _				Date:	
INSURANCE INFORM	IATION - PLI	EASE FAX A CC	PY OF FRO	NT & BAC	OF PRE	ESCI	RIPTION CARE	
		CLINICAL IN	NFORMATIC	N				
Diagnosis:			ICD-10 Code:					
Has the patient been treated p	reviously for th	is condition: Yes [□ No □	Height:	ft	in	Weight:	_ lbs
Allergies:			Medications C	On:				
		_ Medications Failed:						
VTAMA®								
Dosage/Strength: 1% topical cream	1							
Directions: ☐ Apply a thin layer to affected areas	once daily							
Quantity: 60 gram tube								
Refill:								
OTHER								
Dosage/Strength:								
Directions:								
Quantity:								
Dofill:								