NOBLE HEALTH SERVICES

DERMATOLOGY

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

Patient Name: _____ Male: ☐

Address: _____ Female: ☐

City: _____ State: _____ Zip: _____

Email: _____

Last 4 of SSN: _____ DOB: _____

Translator: Yes ☐ No ☐ Language: _____

Patient interested in: Support Programs ☐ Ancillary Supplies ☐

PRESCRIBER INFORMATION

Prescriber: _____

Office Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

DEA/NPI #: _____

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: _____

ACTEMRA®

Dosage/Strength:
- ☐ 162mg/0.9ml prefilled syringe
- ☐ 162mg/0.9ml ACTPen autoinjector

Directions:
- ☐ Inject _____ SC every other week
- ☐ Inject _____ SC every week
- ☐ Other:

Quantity: ☐ 4-week supply

Refill:

ADBRY®

Dosage/Strength:
- ☐ 150mg/ml prefilled syringe

Directions:

Initial Loading Dose:
- ☐ Inject 600mg (4 - 150mg injections) SC on day 1

Maintenance Dose:
- ☐ Inject 300mg (2 - 150mg) SC every 2 weeks

Maintenance Dose option for patients weighing <100kg, stable on Adbry >16 weeks with clear or almost clear skin:
- ☐ Inject 300mg (2 - 150mg) SC every 4 weeks

Quantity: ☐ 4-week supply

Refill:

AMJEVITA® CITRATE-FREE (HUMIRA BIOSIMILAR)

Dosage/Strength:
- ☐ 20mg/0.4ml prefilled syringe
- ☐ 40mg/0.8ml prefilled syringe
- ☐ 40mg/0.8ml prefilled pen

Directions:
- ☐ Inject 40mg every other week
- ☐ Inject 40mg every week

Quantity:

Refill:

BOTOX

Dosage/Strength:
- ☐ 100U Vial ☐ 200U Vial

Directions:
- ☐ Inject _____ units every _____ weeks

Quantity:

Refill:

CIBINQO®

Dosage/Strength:
- ☐ 50mg tablet ☐ 100mg tablet
- ☐ 200mg tablet

Directions:
- ☐ 1 tablet by mouth once daily

Quantity: ☐ 30-day supply ☐ 90-day supply

Refill:

CIMZIA®

Dosage/Strength:
- ☐ 200mg/ml prefilled syringe ☐ Starter Kit

Directions:

Loading Dose:
- ☐ Inject 400mg SC at weeks 0, 2, 4

Maintenance Dose:
- ☐ Inject 200mg SC every other week (option for patients <90kg body weight)
- ☐ Inject 400mg SC every 4 weeks
- ☐ Other:

Quantity: ☐ 4-week supply

Refill:

COSENTYX®

Dosage/Strength:
- ☐ 75mg syringe ☐ 150mg pen
- ☐ 150mg syringe

Directions:

Loading Dose:
- ☐ Inject 150mg at weeks 0, 1, 2, 3, 4
- ☐ Inject 300mg at weeks 0, 1, 2, 3, 4

Maintenance Dose:
- ☐ Inject 150mg every 4 weeks
- ☐ Inject 300mg every 4 weeks

Quantity:
- ☐ 5-week supply (Loading)
- ☐ 4-week supply (Maintenance)

Refill:

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Delivery Needed By:_____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____ Male: ☐

Address: _____ Female: ☐

City: _____ State: _____ Zip: _____

Email: _____

Last 4 of SSN: _____ DOB: _____

Translator: Yes ☐ No ☐ Language: _____

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DEA/NPI #: _____

Signature: _____ Date: _____

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CLINICAL INFORMATION

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Has the patient been treated previously for this condition: Yes ☐ No ☐ Height:_____ ft _____in Weight:_____ lbs

Allergies: _____ Medications On: _____

Other Notes: _____ Medications Failed: _____

DUOBRIL®

Dosage/Strength: ☐ 0.01%/0.045% lotion

Directions:

☐ Apply a thin layer of lotion topically to the affected area(s) once daily

Quantity: ☐ 100 gram tube

Refill:

DUPIXENT®

Dosage/Strength:

☐ 200mg/1.14ml single-dose prefilled syringe
☐ 200mg/1.14ml single-dose prefilled pen
☐ 300mg/2ml single-dose prefilled syringe
☐ 300mg/2ml single-dose prefilled pen

Prefilled pens are approved for use in patients 2 years of age and older.

Directions:

Adult (and Pediatric Patients >60 Kg)

Initial Loading Dose:

☐ Inject 600mg (2-300mg injections) SC on day 1

Maintenance Dose:

☐ Inject 300mg SC every 2 weeks

Pediatric Patients 6 months to 5 years of age

Body Weight **5kg to <15kg** Loading & Maintenance Dose:

☐ Inject 200mg SC every 4 weeks

Body Weight **15kg to <30kg** Loading & Maintenance Dose:

☐ Inject 300mg SC every 4 weeks

Pediatric Patients 6 years to 17 years of age

Body Weight **15kg to <30kg** Loading Dose:

☐ Inject 600mg (2-300mg injections) SC on day 1

Body Weight **15kg to <30kg** Maintenance Dose:

☐ Inject 200mg SC every 4 weeks
☐ Inject 300mg SC every 4 weeks

Body Weight **30kg to <60kg** Loading Dose:

☐ Inject 400mg (2-200mg injections) SC on day 1

Body Weight **30kg to <60kg** Maintenance Dose:

☐ Inject 200mg SC every 2 weeks

Body Weight **60kg or more** Loading Dose:

☐ Inject 600mg (2-300mg injections) SC on day 1

Body Weight **60kg or more** Maintenance Dose:

☐ Inject 300mg SC every 2 weeks

Quantity: ☐ 4-week supply

Refill:

CYLTEZO® CITRATE-FREE (HUMIRA INTERCHANGEABLE BIOSIMILAR)

Dosage/Strength:

☐ 20mg/0.4ml prefilled syringe
☐ 40mg/0.8ml prefilled syringe
☐ 40mg/0.8ml prefilled pen

Directions:

☐ Inject 40mg every other week
☐ Inject 40mg every week

Quantity:

Refill:

ENBREL® AND ENBREL® MINI

Dosage/Strength:

☐ 25mg/0.5ml prefilled syringe
☐ 50mg/ml single-use prefilled syringe
☐ 50mg/ml SureClick autoinjector
☐ 25mg vial
☐ 50mg Enbrel® Mini single-dose prefilled cartridge

Directions:

☐ Inject 25mg SC twice a week (72-96 hrs apart)
☐ Inject 50mg SC twice a week (72-96 hrs apart)
☐ Inject 50mg SC once a week
☐ Other:

Quantity: ☐ 4-week supply

Refill:

HADLIMA® (HUMIRA BIOSIMILAR)

Dosage/Strength:

☐ 40mg/0.4ml syringe
☐ 40mg/0.8ml syringe
☐ 40mg/0.4ml Pushtouch syringe
☐ 40mg/0.8ml Pushtouch syringe

Directions:

☐ Inject 40mg every other week
☐ Inject 40mg every week

Quantity:

Refill:

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PATIENT INFORMATION

Patient Name: _____ Male: ☐

Address: _____ Female: ☐

City: _____ State: _____ Zip: _____

Email: _____

Last 4 of SSN: _____ DOB: _____

Translator: Yes ☐ No ☐ Language: _____

Patient interested in: Support Programs ☐ Ancillary Supplies ☐

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Prescriber: _____

Office Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

DEA/NPI #: _____

Signature: _____ Date: _____

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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: _____

HUMIRA® CITRATE-FREE

Dosage/Strength:
- ☐ 40mg/0.4ml pen
- ☐ 40mg/0.4ml prefilled syringe

Directions:
- ☐ Inject 40mg SC every other week
- ☐ Inject 40mg SC once a week

Quantity: ☐ 4-week supply

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 day 15, maintenance beginning on day 29

Quantity: ☐ 4-week supply

Refill:

HUMIRA® CITRATE-FREE PSORIASIS/UVEITIS STARTER KIT

Dosage/Strength:
- ☐ 80mg/0.8ml pen ☐ 40mg/0.4ml pen x2

Directions:

Loading Dose:
- ☐ Inject 80mg SC day 1, 80mg day 2, 40mg day 8, 40mg maintenance beginning on day 22

Quantity: ☐ 4-week supply

Refill:

ILUMYA®

Dosage/Strength:
- ☐ 100mg/ml single-dose prefilled syringe

Directions:
- ☐ Inject 100mg SC at weeks 0,4, and every 12 weeks thereafter

Quantity: ☐ 4-week supply

Refill:

INFLECTRA®

Dosage/Strength: ☐ 100mg vial

Directions:

Loading Dose:
- ☐ Infuse _____ mg (5mg/kg) at 0, 2, 6 weeks then every 8 weeks thereafter via IV

Maintenance Dose:
- ☐ Infuse _____ mg (5mg/kg) every 8 weeks via IV

Quantity: _____ vials

Refill:

OLUMIANT®

Dosage/Strength: ☐ 2mg tablet ☐ 4mg tablet

Directions: ☐ 1 tablet by mouth once daily

Quantity:

Refill:

OPZELURA™

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: ☐ 60 gram tube ☐ 100 gram tube

Refill:

OTEZLA®

Dosage/Strength:
- ☐ 28-day starter pack titration ☐ 30mg

Directions:
- ☐ Initial Dose titration per starter pack
- ☐ Take 30mg by mouth twice daily

Quantity:
- ☐ Starter Kit ☐ Bottle of 60

Refill:

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PATIENT INFORMATION

Patient Name: _____ Male: ☐

Address: _____ Female: ☐

City: _____ State: _____ Zip: _____

Email: _____

Last 4 of SSN: _____ DOB: _____

Translator: Yes ☐ No ☐ Language: _____

Patient interested in: Support Programs ☐ Ancillary Supplies ☐

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City: _____ State: _____ Zip: _____

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DEA/NPI #: _____

Signature: _____ Date: _____

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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: _____

OTREXUP®

Dosage/Strength:
- ☐ 10mg/0.4ml autoinjector
- ☐ 12.5mg/0.4ml autoinjector
- ☐ 15mg/0.4ml autoinjector
- ☐ 17.5mg/0.4ml autoinjector
- ☐ 20mg/0.4ml autoinjector
- ☐ 22.5mg/0.4ml autoinjector
- ☐ 25mg/0.4ml autoinjector

Directions:
- ☐ Inject _____ mg SC once weekly
- ☐ Other:

Quantity: ☐ 4-week supply

Refill:

RASUVO®

Dosage/Strength:
- ☐ 7.5mg/0.15ml autoinjector
- ☐ 10mg/0.2ml autoinjector
- ☐ 12.5mg/0.25ml autoinjector
- ☐ 15mg/.3ml autoinjector
- ☐ 17.5mg/0.35ml autoinjector
- ☐ 20mg/0.4ml autoinjector
- ☐ 22.5mg/0.45ml autoinjector
- ☐ 25mg/0.5ml autoinjector
- ☐ 27.5mg/0.55ml autoinjector
- ☐ 30mg/0.6ml autoinjector

Directions:
- ☐ Inject _____ mg SC once weekly
- ☐ Other:

Quantity: ☐ 4-week supply

Refill:

RAYOS®

Dosage/Strength:
☐ 1mg tablet ☐ 2mg tablet ☐ 5mg tablet

Directions:
- ☐ Take _____ mg by mouth once per day
- ☐ Other:

Quantity: ☐ _____-day supply

Refill:

REMICADE®

Dosage/Strength: ☐ 100mg vial

Directions:

Loading Dose:
- ☐ Infuse _____ mg (5mg/kg) at 0, 2, 6 weeks, then every 8 weeks thereafter via IV

Maintenance Dose:
- ☐ Infuse _____ (5mg/kg) every 8 weeks via IV
- ☐ Infuse _____ (5mg/kg) every _____ weeks via IV
- ☐ Other:

Quantity: ☐ _____ vials

Refill:

RENFLEXIS®

Dosage/Strength: ☐ 100mg vial

Directions:

Loading Dose:
- ☐ 5mg/kg (Dose _____ mg) IV at weeks 0, 2, 6 then every 8 weeks thereafter

Maintenance Dose:
- ☐ 5mg/kg (Dose _____ mg) IV every 8 weeks
- ☐ IV _____ every _____ weeks
- ☐ Other:

Quantity: ☐ _____ vials

Refill:

RINVOQ™

Dosage/Strength: ☐ 15mg tablet ☐ 30mg tablet

Directions: ☐ Take one tablet by mouth once daily

Quantity: ☐ 30-day supply

Refill:

SILIQ™

Dosage/Strength:
- ☐ 210mg/1.5ml prefilled syringe

Directions:
- ☐ Inject 210mg SC at weeks 0, 1, 2 and 210mg SC every 2 weeks thereafter

Quantity:
- ☐ Starter Dose (3 syringes)
- ☐ Maintenance Dose (2 syringes)

Refill:

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PATIENT INFORMATION

Patient Name: _____ Male: ☐

Address: _____ Female: ☐

City: _____ State: _____ Zip: _____

Email: _____

Last 4 of SSN: _____ DOB: _____

Translator: Yes ☐ No ☐ Language: _____

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Signature: _____ Date: _____

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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: _____

SIMPONI®

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
- ☐ Inject 200mg SC at week 0, 100mg at week 2 then 100mg every 4 weeks thereafter

Quantity: ☐ 4-week supply

Refill:

SKYRIZI®

Dosage/Strength:
- ☐ 150mg/mL prefilled syringe
- ☐ 150mg/mL pen

Directions:

Loading Dose:
- ☐ Inject 150mg SC at weeks 0, 4, and every 12 weeks thereafter

Maintenance Dose:
- ☐ Inject 150mg SC every 12 weeks

Quantity: ☐ 1 prefilled syringe/pen

Refill:

STELARA®

Dosage/Strength:
- ☐ 45mg/0.5ml prefilled syringe
- ☐ 90mg/ml prefilled syringe

Directions:

Patients weighing <100kg:
- ☐ Inject 45mg SC at 0 and 4 weeks, then every 12 weeks thereafter

Maintenance Dose:
- ☐ Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter

Quantity:
- ☐ 2 syringes (Loading)
- ☐ 1 syringe (Maintenance)

Refill:

SOTYKYU®

Dosage/Strength: ☐ 6mg tablet

Directions:
- ☐ Take 1 tablet (6mg) by mouth once daily

Quantity: ☐ 30-day supply

Refill:

TALTZ®

Dosage/Strength:
- ☐ 80mg/ml single-dose prefilled autoinjector
- ☐ 80mg/ml single-dose prefilled syringe

Directions:

Loading Dose:
- ☐ Inject 160mg SC at week 0 followed by 80mg SC on weeks 2, 4, 6, 8, 10, 12

Maintenance Dose:
- ☐ Inject 80mg SC every 4 weeks

Quantity:
- ☐ 3 syringes/pens ☐ 2 syringes/pens
- ☐ 1 syringe/pen

Refill:

TREMFYA®

Dosage/Strength:
- ☐ 100mg/ml prefilled syringe
- ☐ 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

Quantity:
- ☐ 4 week supply (Loading)
- ☐ 8 week supply (Maintenance)

Refill:

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Translator: Yes ☐ No ☐ Language: _____

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Allergies: _____ Medications On: _____

Other Notes: _____ Medications Failed: _____

VTAMA®

Dosage/Strength: ☐ 1% topical cream

Directions:
☐ Apply a thin layer to affected areas once daily

Quantity: ☐ 60 gram tube

Refill:

OTHER

Dosage/Strength:

Directions:

Quantity:

Refill: