E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE NEW YORK**
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Hormonal Therapies

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

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPI #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches 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:
Firmagon®	☐ 120 mg vial ☐ 80 mg vial	Initial Dose: ☐ Inject 240mg (2-120mg injections) SC	Maintenance Dose: ☐ Inject 80 mg SC every 28 days	☐ 4 week supply ☐ Other	
Lupaneta Pack™ (leuproline, norethindrone)	☐ 3.75 mg suspension for injection, 5mg tablet ☐ 11.25 mg suspension for injection, 5mg tablet	☐ 3.75mg IM once monthly, 5mg tablet by mouth once daily ☐ 11.25mg IM once every 3 months, 5mg tablet by mouth once daily		☐ 1 pack ☐ Other	
Lupron Depot®	☐ 3.75 suspension for injection ☐ 7.5mg suspension for injection ☐ 11.25 mg suspension for injection ☐ 22.5mg suspension for injection ☐ 30mg suspension for injection ☐ 45mg suspension for injection	☐ _____mg IM once monthly ☐ _____mg IM once every 3 months ☐ _____mg once every 4 months ☐ _____mg once every 6 months		☐ 1 dose ☐ Other	
Supprelin® LA	☐ 50 mg SC implant	☐ 1 implant inserted SC every 12 months		☐ 1 implant ☐ Other	
Trelstar®	☐ 3.75 mg suspension for injection ☐ 11.25 mg suspension for injection ☐ 22.5 mg suspension for injection	☐ _____mg IM once monthly ☐ _____mg IM once every 3 months ☐ _____mg once every 6 months		☐ 1 dose ☐ Other	
Vantas	☐ 50 mg SC implant	☐ 1 implant inserted SC every 12 months		☐ 1 implant ☐ Other	
Zoladex	☐ 3.6 mg implant ☐ 10.8 mg implant	☐ 3.6 mg subcutaneous into the upper abdominal wall every 28 days ☐ 10.8 mg subcutaneous into the upper abdominal wall once every 12 weeks ☐ Other		☐ 1 dose ☐ Other	
Other					

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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