E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ NOBLE SYRACUSE
Tel: 888-843-2040
Fax: **888-842-3977**

☐ NOBLE MISSISSIPPI
Tel: 866-420-4041
Fax: **601-420-4040**

Osteoarthritis

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

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ______________ ☐ Male	Prescriber's Name: ______________
Address: ______________ ☐ Female	Office Contact Name: ______________
City: __________ State: ________ Zip: ________	Address: ______________
Phone Number: ______________	City: __________ State: ________ Zip: ________
Email Address: ______________	Phone Number: __________ Fax: __________
Last Four of Social: __________ DOB: __________	DEA/NPA #: ______________

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ______________	Has the patient been treated previously for this condition?
ICD-10 Code: ______________	☐ Yes ☐ No
Height: ______ ft ______ inches Weight: ______lbs	Medications Failed: ______________
Allergies: ______________	Medications On: ______________
	Other Notes: ______________

SCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Duexis	☐ 800mg/26.6 mg tablet	☐ Take 1 tablet by mouth ___ time(s) a day	☐ ___ day supply	
Euflexxa	☐ 20mg / 2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for three weeks. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ______ Prefilled Syringes	
Gel-One	☐ 30mg/3mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ______ Prefilled Syringes	
Hyalgan	☐ 20 mg/2ml prefilled syringe ☐ 20 mg/2ml vial	☐ Inject contents of prefilled syringe intra-articularly once a week for five weeks Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ______ Prefilled Syringes ☐ ______ Vials	
Monovisc	☐ 88mg/4ml prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ______ Prefilled Syringes	
Orthovisc	☐ 30 mg/2ml prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for ___ weeks. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ______ Prefilled Syringes	
Pennsaid	☐ 40mg/2% pump	☐ Dispense 40mg (2 pump actuations) directly onto knee or first into hand then onto knee.	☐ ________ Pumps	
Supartz	☐ 25 mg/2.5ml prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for five weeks. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ______ Prefilled Syringes	
Synvisc	☐ 16 mg/2.5ml prefilled syringe	☐ Inject contents of prefilled syringe/ intra-articularly once a week for three weeks. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ______ Prefilled Syringes	

☐ Include one 20G 1.5" needle per syringe	☐ Patient is interested in patient support programs	☐ Ancillary supplies provided for administration

Physician Signature: ______________________________ Date: ____________________

__Important Notice:__ This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy.

E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE SYRACUSE**
Tel: 888-843-2040
Fax: **888-842-3977**

☐ **NOBLE MISSISSIPPI**
Tel: 866-420-4041
Fax: **601-420-4040**

Osteoarthritis

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

Patient Name: _______________________ DOB: ________ Prescriber's Name: _____________________________________

PRESCRIPTION INFORMATION				
Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Synvisc One	☐ 48 mg/6 ML prefilled syringe	☐ Inject contents of prefilled syringe/ intra-articularly one time. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ______ Prefilled Syringes	
Vimovo	☐ 375/20 500/20 delayed- release tablets	☐ Take one tablet by mouth ____ time(s) a day	☐ ___ day supply	
Other				

☐ Include one 20G 1.5" needle per syringe	☐ Patient is interested in patient support programs	☐ Ancillary supplies provided for administration

Physician Signature: ____________________________________ Date: _________________________

Important Notice: *This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy.*