# Asthma/Allergy Enrollment Form

www.noblehealthservices.com

***Signature Care Program***

☐ **Noble Syracuse**
Phone: (888) 843-2040
Fax: (888) 842-3977
☐ **Noble Mississippi**
Phone: (866) 420-4041
Fax: (601) 420-4040

Delivery Need By: Delivery to: ☐Patients Home ☐Physician's Office ☐Other

| PATIENT INFORMATION | PRESCRIBER INFORMATION |
|---|---|
| Patient Name: ☐Female ☐Male | Prescriber Name: |
| Address: | Address: |
| City, State, Zip: , , | City, State, Zip: , , |
| Phone: | Phone: |
| Date of Birth: | Fax: |
| Last Four of Social Security Number: | DEA/NPI#: |

## INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

## CLINICAL INFORMATION

| | |
|---|---|
| Diagnosis: | Has the patient been treated previously for this condition? ☐ Yes ☐ No |
| ICD-10 Code: | Medications failed: |
| Height: feet inches Weight: lbs. | Medications on: |
| Allergies: | Other notes: |

## PRESCRIPTION INFORMATION

| Medication: | Dosage/Strength: | Directions: | Quantity: | Refills: |
|---|---|---|---|---|
| **Cinqair** | ☐ 100MG/10ML VIAL | ☐ Inject ______ mg (3mg/kg every 4 weeks IV infusion) | _____Vials<br>☐ 30-day supply<br>☐ 90-day supply<br>☐ Other | |
| **Xolair®** | ☐ 75 mg/0.5 mL in a single-dose prefilled syringe<br>☐ 150 mg/mL solution in a single-dose prefilled syringe<br>☐ 150 mg lyophilized powder in a single-dose vial for reconstitution | ☐ Inject ______ mg every 2 weeks<br>☐ Inject ______ mg every 4 weeks<br>☐ Other | ☐ 30-day supply<br>☐ 90-day supply<br>☐ Other | |
| **Dupixent®** | ☐ 200 mg/1.14 mL solution in a single-dose pre-filled syringe<br>☐ 300 mg/2 mL solution in a single-dose pre-filled syringe | Starting Dose:<br>☐ 400 mg (two 200 mg injections)<br>☐ 600 mg (two 300 mg injections)<br><br>Maintenance Dose:<br>☐ 200 mg every other week<br>☐ 300 mg every other week | ☐ 30-day supply<br>☐ 90-day supply<br>☐ Other | |
| **Other:** | | | | |

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

Office Contact Name: __________________________ Preferred Phone Number & Extension: __________________________

Physician Signature: __________________________ Date: ____________

## E-Scribe Rx and Fax this Form

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