E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ NOBLE NEW YORK
Tel: 888-843-2040
Fax: 888-842-3977

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

Autoimmune

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: _____
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:
Actemra	☐ 162 mg/0.9 ml ☐ 162 mg/0.9 ml	☐ Inject SC every OTHER week ☐ Inject SC every week ☐ Other	☐ 4 week supply	
Cimzia	☐ 200 mg/ml Prefilled SYR ☐ Starter Kit	Loading Dose: ☐ Inject 400 mg SC at weeks 0, 2 and 4 Maintenance Dose: ☐ Inject 200 mg SC every other week ☐ Inject 400 mg SC every 4 weeks ☐ Other	☐ 4 week supply	
Enbrel *Enbrel Mini Available*	Mini: ☐ 50mg **Enbrel Mini** single dose prefilled cartridge Standard: ☐ 25mg/0.5ml prefilled syringe ☐ 50mg/ml single use prefilled SYR ☐ 50mg/ml SureClick Autoinjector ☐ 25mg Vial	☐ Inject 50mg SC twice a week (72-96 Hours apart) ☐ Inject 50mg SC once a week ☐ Inject 25 mg SC twice a week (72-96 hours apart) ☐ Other	☐ 4 week supply	
Humira® Citrate-Free	☐ 40mg/0.4 ml Pen ☐ 40 mg/0.4 ml Prefilled SYR	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC once a week ☐ Other	☐ 4 week supply	
Orencia	☐ 250 mg Vial ☐ 125 mg/ml SYR ☐ 125 mg/ml Clickject	☐ Infuse _____ mg at weeks 0, 2, 4 then every 4 weeks thereafter ☐ Inject 125 mg once a week ☐ Other	☐ 4 week supply	
Otezla	☐ 30 mg tablet ☐ Starter Kit	☐ Take 30 mg by mouth twice daily ☐ Use directions on starter kit ☐ Other	☐ 4 week supply	

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

Physician Signature: _____ Date: _____

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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/NPA #: _____

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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:
Remicade	☐ 100 mg vial	Induction Dose: ☐ Infuse ____mg (___mg/kg) at 0, 2 and 6 weeks via IV Maintenance Dose: ☐ Infuse ___mg (__mg/kg) every 8 weeks via IV ☐ Infuse ____mg (___mg/kg) every ____ weeks via IV ☐ Other	☐ _____ # of Vials	
Rituxan	☐ 100 mg/10 ml Vial ☐ 500 mg/ 50 ml Vial	☐ Specified	☐ _____ # of Vials	
Simponi	☐ 100mg/1ml SmartJect Autoinjector ☐ 100 mg/1 ml Prefilled SYR ☐ 50mg/0.5 ml SmartJect Autoinjector ☐ 50mg/ ml Prefilled Syringe	☐ Inject 100 mg SC ONCE a month ☐ Inject 50 mg SC ONCE a month ☐ Other	☐ 4 week supply	
Tremfya	☐ 100 mg/mg Prefilled SYR	☐ Inject _____ at weeks 0,4, then every 8 weeks thereafter ☐ Other	☐ Loading Dose/ 4 week supply ☐ Maintenance/ 8 Week Supply	
Xeljanz	☐ 5mg tablet	☐ Take one tablet by mouth twice daily ☐ Other	☐ 4 week supply	
Xeljanz XR	☐ 11 mg tablet	☐ Take one tablet by mouth once a day ☐ Other	☐ 4 week supply	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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