



# ENDOCRINOLOGY

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	PROVIDER INFORMATION
Patient Name: _____ <input type="checkbox"/> Male	Prescriber's Name: _____
Street Address: _____ <input type="checkbox"/> Female	Office Contact Name: _____
City: _____ State: _____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: _____ Zip Code: _____
Email Address: _____	Phone Number: _____ Fax Number: _____
Last Four of Social: _____ Date of Birth: _____	DEA/NPI #: _____

## INSURANCE - PLEASE FAX A COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION	
Diagnosis: _____	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
ICD-10 Code: _____	
Height: _____ ft _____ ins Weight: _____ lbs	Medications Failed: _____
Allergies: _____	Medications On: _____
Other Notes: _____	

PRESCRIPTION INFORMATION				
Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Afrezza*	<input type="checkbox"/> Titration Pack - (4&8 unit) <input type="checkbox"/> Titration Pack - (4,8&12 unit) <input type="checkbox"/> 4-unit cartridge <input type="checkbox"/> 8-unit cartridge <input type="checkbox"/> 12-unit cartridge	<input type="checkbox"/> Administer using a single inhalation per cartridge at beginning of a meal		
Sandostatin*	<u>Ampules:</u> <input type="checkbox"/> 50mcg/ml <input type="checkbox"/> 100mcg/ml <input type="checkbox"/> 500mcg/ml  <u>Multi-Dose Vial:</u> <input type="checkbox"/> 200mcg/ml (5ml) <input type="checkbox"/> 1000mcg/ml (5ml)	<input type="checkbox"/> Administer _____ mcg subcutaneously three times a day <input type="checkbox"/> Other	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply	
Sandostatin* LAR	<input type="checkbox"/> 10mg vial kit <input type="checkbox"/> 20mg vial kit <input type="checkbox"/> 30mg vial kit	<input type="checkbox"/> Administer _____ mg intragluteally every 4 weeks (Mix the contents of vial with diluent) <input type="checkbox"/> Other	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply	
Sensipar*	<input type="checkbox"/> 30mg tablet <input type="checkbox"/> 60mg tablet <input type="checkbox"/> 90mg tablet	<input type="checkbox"/> Take _____ mg by mouth once daily with food <input type="checkbox"/> Other	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply	
Somatuline* Depot	<input type="checkbox"/> 60mg prefilled syringe <input type="checkbox"/> 90mg prefilled syringe <input type="checkbox"/> 120mg prefilled syringe	<input type="checkbox"/> Inject _____ mg by deep subcutaneous injection every 4 weeks	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply	
31G Pen Needles	<input type="checkbox"/> 5mm <input type="checkbox"/> 6mm <input type="checkbox"/> 8mm		<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply	
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration		

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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