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**

Dermatology

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: _____ Fax: _____
DEA/NPI#: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____
ICD-10 Code: _____
Height: _____ ft _____ inches Weight: _____ lbs
Last PPD Test: ☐ Positive ☐ Negative Date: _____
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 *ACTPen* Autoinjector	☐ Inject _____ mg SC every OTHER week ☐ Inject _____ mg SC every week ☐ Other		☐ 4 week supply	
Botox	☐ 100U Vial ☐ 200U Vial	☐ Inject _____ units every _____ weeks		☐ _____ vials	
Cimzia®	☐ 200 mg/ml Prefilled syringe ☐ Starter Kit	Loading Dose: ☐ Inject 400 mg SC at weeks 0, 2 and 4	Maintenance Dose: ☐ 200 mg SC every other week ☐ 400 mg SC every 4 weeks	☐ 4 week supply	
		☐ Other			
Cosentyx® **Enhanced Specialty Pharmacy Program Participant*	☐ 150 mg Pen ☐ 150 mg prefilled syringe	Loading Dose: ☐ Inject 150 mg SC at weeks 0, 1, 2, 3, 4 ☐ Inject 300 mg SC at weeks 0, 1, 2, 3, 4	Maintenance Dose: ☐ Inject 150 mg SC every 4 weeks ☐ Inject 300 mg SC every 4 weeks	☐ 5 week supply (loading) ☐ 4 week supply (maintenance)	
Cosentyx® **Enhanced Specialty Pharmacy Program Participant* ***Covered Until You're Covered***	☐ 150 mg Pen ☐ 150 mg prefilled syringe	Loading Dose: ☐ Inject 150 mg SC at weeks 0, 1, 2, 3, 4 ☐ Inject 300 mg SC at weeks 0, 1, 2, 3, 4	Maintenance Dose: ☐ Inject 150 mg SC every 4 weeks ☐ Inject 300 mg SC every 4 weeks	☐ 5 week supply (loading) ☐ 4 week supply (maintenance)	
Duobrii®	☐ 0.01%/0.045% lotion	☐ Apply a thin layer of lotion topically to the affected area(s) once daily		☐ 100 gram tube	
Dupixent	☐ 300 mg/2 ml Prefilled syringe ☐ 200 mg/1.14 ml prefilled syringe	Loading Dose: ☐ Inject 600 mg (2-300 mg injections) SC on day 1	Maintenance Dose: ☐ Inject 300 mg SC every 2 weeks	☐ 4 week supply (maintenance)	
		Adolescents <60 kg: ☐ Loading Dose: Inject 400mg (2-200mg injections) subcutaneously on day 1	Adolescents <60 kg: ☐ Maintenance Dose: Inject 200mg every 2 weeks		

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

Physician Signature: _____ Date: _____

v. Q120202g

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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: _____ Fax: _____
DEA/NPI#: _____

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Height: _____ ft _____ inches Weight: _____ lbs
Last PPD Test: ☐ Positive ☐ Negative Date: _____
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:
Enbrel® ***Enbrel Mini® Available***	Standard: ☐ 25mg/0.5ml Prefilled syringe ☐ 50mg/ml Prefilled syringe ☐ 50mg/ml SureClick Autoinjector ☐ 25mg Vial Mini: ☐ 50mg Enbrel Mini single dose prefilled cartridge	☐ Inject 50mg SC TWICE a week (72-96 hours apart) ☐ Inject 50mg SC ONCE a week ☐ Inject 25mg SC TWICE a week (72-96 hours apart) ☐ Other	☐ 4 week supply	
Humira® HS Starter Kit **Citrate-Free**	☐ 80 mg/0.8ml Pen x3	Loading Dose: ☐ Inject 160 mg day 1, 80 mg day 15, maintenance beginning on day 29 ☐ Inject 80 mg on day 1, 80mg on day 2, 80mg on day 15, maintenance beginning on day 29	☐ 4 week supply	
Humira® Psoriasis/Uveitis Starter Kit **Citrate-Free**	☐ 80mg/0.8ml Pen x1, 40mg/0.4ml Pen x2	Loading Dose: ☐ Inject 80 mg SC day 1, 40 mg day 8, 40 mg maintenance beginning on day 22	☐ 4 week supply	
Humira® **Citrate-Free**	☐ 40mg/0.4ml Pen ☐ 40mg/0.4ml Prefilled SYR	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	☐ 4 week supply	
Ilumya™	☐ 100 mg/ml single-dose prefilled syringe	☐ Inject 100 mg subcutaneously at weeks 0, 4, and every twelve weeks thereafter	☐ 4 week supply	
Inflectra®	☐ 100 mg VIAL	Loading Dose: ☐ Infuse ____mg (5mg/kg) at 0,2 and 6 weeks then every 8 weeks thereafter via IV Maintenance Dose: ☐ Infuse ____ mg (5mg/kg) every 8 weeks via IV	☐ _____Vials	
Otezla®	☐ 28 day starter pack titration ☐ 30mg	☐ Initial dosage titration per starter pack ☐ Take 30mg by mouth twice daily	☐ 1 month starter pack ☐ Bottle of 60	
Otrexup	Autoinjector: ☐ 10 mg / 0.4 ml ☐ 12.5 mg/ 0.4 ml ☐ 15mg/ 0.4 ml ☐ 17.5mg/ 0.4 ml ☐ 20mg/ 0.4 ml ☐ 22.5mg/ 0.4 ml ☐ 25mg/ 0.4 ml	☐ Inject _____ mg subcutaneously once weekly ☐ Other	☐ 4 week supply	
☐ Patient is interested in patient support programs		☐ Ancillary supplies provided for administration		

Physician Signature: _____ Date: _____

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Email Address: _____
Last Four of Social: _____ DOB: _____

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Height: _____ ft _____ inches Weight: _____ lbs
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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:
Rasuvo®	Autoinjector: ☐ 7.5 mg/0.15ml ☐ 20 mg/0.4ml ☐ 10 mg/0.2ml ☐ 22.5 mg/0.45ml ☐ 12.5 mg/0.25ml ☐ 25 mg/0.5ml ☐ 15 mg/.3ml ☐ 27.5 mg/0.55ml ☐ 17.5 mg/0.35ml ☐ 30 mg/0.6ml	☐ Inject ____ mg by mouth once per day ☐ Other	☐ 4 week supply	
Rayos®	☐ 1 mg tablet ☐ 2 mg tablet ☐ 5 mg tablet	☐ Take ____ mg by mouth daily	☐ ____ day supply	
Remicade®	☐ 100 MG VIAL	Loading Dose: ☐ Infuse ____mg (5mg/kg) at 0,2 and 6 weeks then every 8 weeks thereafter via IV Maintenance Dose: ☐ Infuse ____ mg (5mg/kg) every 8 weeks via IV ☐ Infuse ____mg (5mg/kg) every ___ weeks via IV ☐ Other	☐ _____ Vials	
Renflexis®	☐ 100 MG VIAL	Loading Dose: ☐ Infuse ____mg (5mg/kg) at 0,2 and 6 weeks then every 8 weeks thereafter via IV Maintenance Dose: ☐ Infuse ____ mg (5mg/kg) every 8 weeks via IV	☐ _____ Vials	
Siliq™	☐ 210mg/1.5ml Prefilled SYR	☐ Inject 210mg SC at weeks: 0, 1 and 2 and 210mg SC every 2 weeks thereafter	☐ Starter Dose (3 SYR) ☐ Maintenance Dose (2 SYR)	
Simponi®	☐ 100mg/1ml SmartJect Autoinjector ☐ 100mg/1ml Prefilled SYR ☐ 50mg/0.5ml SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled SYR	☐ Inject 100mg SC ONCE a month ☐ Inject 50mg SC ONCE a month	☐ 4 week supply	
☐ Patient is interested in patient support programs		☐ Ancillary supplies provided for administration		

Physician Signature: _____ Date: _____

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PRESCRIBER INFORMATION

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Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
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Last PPD Test: ☐ Positive ☐ Negative Date: _____
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:
Skyrizi™	☐ 75 mg/0.83 ml prefilled syringe	Loading Dose: ☐ Inject 150 mg (2-75mg syringes) SC at weeks 0, 4, and every 12 weeks thereafter	Maintenance Dose: ☐ Inject 150 mg SC every 12 weeks	☐ _____ prefilled syringes	
Stelara®	☐ 45mg/0.5ml Prefilled SYR ☐ 90mg/ml Prefilled SYR	☐ Patients weighing ≤100kg : Inject 45mg SC at 0 and 4 weeks, then every 12 weeks thereafter ☐ Patients weighing >100kg: Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter		☐ 2 SYR (loading) ☐ 1 SYR (maintenance)	
Taltz®	☐ 80mg/ml single-dose Prefilled Autoinjector ☐ 80mg/ml single-dose Prefilled SYR	Loading Dose: ☐ Inject 160mg SC at week 0 followed by 80mg SC on weeks 2, 4, 6, 8, 10 and 12	Maintenance Dose: ☐ Inject 80mg SC every 4 weeks	☐ 3 syringes/pens ☐ 2 syringes/pens ☐ 1 syringe/pen	
Tremfya®	☐ 100mg/ml Prefilled SYR ☐ 100 mg/ml prefilled autoinjector	☐ Inject _____ mg SC at weeks 0, 4, then every 8 weeks thereafter		☐ 4 week supply (loading) ☐ 8 week supply (maintenance)	
Other					

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

Physician Signature: _____ Date: _____

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