NOBLE HEALTH SERVICES

HEPATITIS B

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

Patient Name: _____ ☐ Male

Street Address: _____ ☐ Female

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Last Four of Social: _____ Date of Birth: _____

Translator Needed: ☐ Yes ☐ No Language: _____

PROVIDER INFORMATION

Prescriber's Name: _____

Office Contact Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Fax Number: _____

DEA/NPI: _____

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

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Viral Load: _____ Genotype: _____

Metavir Fibrosis Score: _____

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Cirrhosis: ☐ Yes ☐ No

If yes, decompensated? ☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Baraclude®	☐ 0.5mg tablet ☐ 1mg tablet ☐ 0.05mg/ml solution	☐ Take one 0.5mg tablet by mouth daily ☐ Take one 1mg tablet by mouth daily ☐ Take _____ ml by mouth daily	☐ 30-day supply	
Epivir HBV	☐ 100mg tablet ☐ 5mg/mL solution	☐ Take one 100mg tablet by mouth daily ☐ Take _____ ml by mouth daily	☐ 30-day supply	
Hepsera®	☐ 10mg tablet	☐ Take one 10 mg tablet by mouth daily	☐ 30-day supply	
Intron-A	☐ 10million unit powder for injection ☐ 25million unit solution for injection ☐ Other			
Pegasys®	☐ 180mcg/ml Single-Dose Vial ☐ 180mcg/0.5ml prefilled syringe ☐ 180mcg/0.5ml autoinjector	☐ Inject 180mcg SC once weekly	☐ 28-day supply	
Vemlidy®	☐ 25mg tablet	☐ Take one 25mg tablet by mouth daily with food	☐ 30-day supply	
Viread®	☐ 300mg tablet	☐ Take one 300mg tablet by mouth daily	☐ 30-day supply	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

NATIONALLY ACCREDITED. **100% EMPLOYEE OWNED.**

www.noblehealthservices.com