E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE NEW YORK**
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Asthma and Allergy

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 Number: _____ Fax: _____
DEA/NPI #: _____

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:
Cinqair®	☐ 100MG/10ML VIAL	☐ Infuse _____ mg (3mg/kg) every 4 weeks via IV infusion		☐ _____Vials ☐ 30-day supply ☐ 90-day supply ☐ Other	
Dupixent®	☐ 200 mg/1.14 mL solution in a single-dose pre-filled syringe ☐ 300 mg/2 mL solution in a single-dose pre-filled syringe	Loading Dose: ☐ Inject 400 mg (two 200 mg injections) SC on day 1 ☐ Inject 600 mg (two 300 mg injections) SC on day 1	Maintenance Dose: ☐ Inject 200 mg SC every other week ☐ Inject 300 mg SC every other week	☐ 30-day supply ☐ 90-day supply ☐ Other	
Xolair®	☐ 75 mg/0.5 mL in a single-dose prefilled syringe ☐ 150 mg/mL solution in a single-dose prefilled syringe ☐ 150 mg powder for injection	☐ Inject _____ mg SC every 2 weeks ☐ Inject _____ mg SC every 4 weeks ☐ Other		☐ 30-day supply ☐ 90-day supply ☐ Other	
Other					

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

Physician Signature: _____ Date: _____

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