



RHEUMATOLOGY

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: ☐ Prescriber: _____

Address: _____ Female: ☐ Office Contact: _____

City: _____ State: _____ Zip: _____ Address: _____

Phone: _____ Email: _____ City: _____ State: _____ Zip: _____

Last 4 of SSN: _____ DOB: _____ Phone: _____ Fax: _____

Translator: Yes ☐ No ☐ Language: _____ DEA/NPI #: _____

Patient interested in: Support Programs ☐ Ancillary Supplies ☐ Signature: _____ Date: _____

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

CLINICAL INFORMATION

Diagnosis: _____ ICD-10 Code: _____

Has the patient been treated previously for this condition: Yes ☐ No ☐ Height: _____ ft _____ in Weight: _____ lbs

Allergies: _____ Medications On: _____

Other Notes: _____ Medications Failed: _____

MEDICATION INFORMATION

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Actemra® | <input type="checkbox"/> Inflectra® | <input type="checkbox"/> Rinvoq™ |
| <input type="checkbox"/> Amjevita® Citrate-free (Humira Biosimilar) | <input type="checkbox"/> Kevzara® | <input type="checkbox"/> Rituxin® |
| <input type="checkbox"/> Cimzia® | <input type="checkbox"/> Olumiant® | <input type="checkbox"/> Simponi® |
| <input type="checkbox"/> Cosentyx® | <input type="checkbox"/> Orencia® | <input type="checkbox"/> Simponi Aria® |
| <input type="checkbox"/> Cuprimine® (penicillamine) | <input type="checkbox"/> Otezla® | <input type="checkbox"/> Skyrizi® |
| <input type="checkbox"/> Cyltezo® Citrate-free (Humira Interchangeable Biosimilar) | <input type="checkbox"/> Otrexup® | <input type="checkbox"/> Taltz® |
| <input type="checkbox"/> Depen (penicillamine) | <input type="checkbox"/> Rasuvo® | <input type="checkbox"/> Tremfya® |
| <input type="checkbox"/> Enbrel® | <input type="checkbox"/> Rayos® | <input type="checkbox"/> Xeljanz® |
| <input type="checkbox"/> Enbrel® Mini | <input type="checkbox"/> Remicade® | <input type="checkbox"/> Xeljanz XR® |
| <input type="checkbox"/> Hadlima® (Humira Biosimilar) | <input type="checkbox"/> Renflexis® | <input type="checkbox"/> Other: _____ |

Dosage/Strength:	Directions:	Quantity:	Refills:	Dispense as Written:

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