E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE NEW YORK**
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Hepatitis C

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: _____

Viral Load : _____ Genotype: _____

Metavir Fibrosis Score: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Cirrhosis: ☐ Yes ☐ No
If yes, Decompensated? ☐ Yes ☐ No
Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Daklinza	☐ 30mg Tablet ☐ 60mg Tablet ☐ 90 mg Tablet	☐ Take one tablet by mouth once daily	☐ 4 week Supply	
Epclusa®	☐ 400-100mg Tablet	☐ Take one tablet by mouth once daily	☐ 4 week supply	
Harvoni®	☐ 90-400 mg tablets	☐ Take one tablet by mouth once daily	☐ 4 week supply	
Mavyret®	☐ 100/40 mg	☐ Take 3 tablets by mouth 1 time daily with food	☐ 4 week supply	
Pegasys®	☐ 180 mcg/ml Single Dose Vial ☐ 180 mcg/0.5ml prefilled syringe ☐ 180 mcg/0.5 ml autoinjector	☐ Inject 180 mcg subcutaneously once weekly	☐ 4 week supply	
Ribavirin®	☐ 200mg Tablet ☐ 200mg Capsules	☐ Take _____ tablet(s) by mouth ____ time(s) daily ☐ Take _____ capsule(s) by mouth _____ time(s) daily	☐ 4 week supply	
Solvaldiz®	☐ 400mg Tablet	☐ Take one tablet by mouth once daily	☐ 4 week supply	
Viekira Pak®	☐ 12.5/75/50-250mg Dosepack	☐ Take two 12.5/75/50mg tablets by mouth daily every morning and one 250mg tablet by mouth twice (morning and evening) with meal.	☐ 4 week supply	
Viekira XR®	☐ 8.33/50/33.33-200mg Dosepack	☐ Take 3 tablets by mouth once daily	☐ 4 week Supply	
Vosevi®	☐ 400/100/100mg tablet	☐ Take 1 tablet by mouth once a day with food	☐ 4 week Supply	
Zepatier ®	☐ 50mg/100mg tablets	☐ One tablet by mouth once a day with or without food	☐ 4 week supply	
Other				

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

Physician Signature: _____ Date: _____

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