NOBLE HEALTH SERVICES

HEPATITIS C
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: _____

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:
Daklinza	☐ 30mg tablet ☐ 60mg tablet ☐ 90mg 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	
Epclusa generic: Sofosbuvir; Velpatasvir	☐ 400-100mg tablet	☐ Take one tablet by mouth once daily	☐ 4-week supply	
Harvoni®	☐ 90-400mg tablet	☐ Take one tablet by mouth once daily	☐ 4-week supply	
Harvoni generic: Ledipasvir; Sofosbuvir	☐ 90-400mg tablet	☐ Take one tablet by mouth once daily	☐ 4-week supply	
Mavyret®	☐ 100/40mg tablet	☐ Take 3 tablets by mouth one time daily with food	☐ 4-week supply	
Pegasys®	☐ 180mcg/ml single-dose vial ☐ 180mcg/0.5ml prefilled syringe ☐ 180mcg/0.5ml autoinjector	☐ Inject 180mcg SC once weekly		
Ribavirin®	☐ 200mg tablet ☐ 200mg capsule	☐ Take _____ tablet(s) by mouth _____ time(s) daily ☐ Take _____ capsule(s) by mouth _____ time(s) daily	☐ 4-week supply	
Solvaldi®	☐ 400 mg tablet	☐ Take one tablet by mouth once daily	☐ 4-week supply	
Vosevi®	☐ 400/100/100mg tablet	☐ Take one tablet by mouth once a day with food	☐ 4-week supply	
Zepatier®	☐ 50/100mg tablet	☐ Take one tablet by mouth once a day with food	☐ 4-week supply	
Other				

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

Physician Signature: _____ Date: _____

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