E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE NEW YORK**
Tel: 888-843-2040
Fax: **888-842-3977**

☐ **NOBLE MISSISSIPPI**
Tel: 866-420-4041
Fax: **601-420-4040**

Pulmonology

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/NPA #: _____

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:
Adcirca	☐ 20 mg tablet	☐ Take 40 mg (2 tablets) once a day ☐ Other	☐ _____ day Supply ☐ Other	
Ambrisentan	☐ 5 mg tablet ☐ 10 mg tablet	☐ Take 5 mg by mouth once daily ☐ Take 10 mg by mouth once daily ☐ Other	☐ 30 day supply ☐ Other	
Bethkis	☐ 300 mg/4ml ampule	☐ Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug ☐ Other	☐ 4 week supply	
Bosentan	☐ 62.5 mg film-coated tablet ☐ 125 mg film-coated tablet ☐ 32 mg tablet for oral suspension	☐ Take 62.5 mg by mouth twice daily ☐ Take 125 mg by mouth twice daily ☐ Other		
Cinqair	☐ 100 mg/10 mg vial	☐ Infuse _____ mg (3mg/kg) every 4 weeks via IV ☐ Other	☐ _____Vials ☐ 30 day supply ☐ 90day 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 400mg SC (2- 200mg injections) on day 1 ☐ Inject 600 mg SC (2-200 mg injections) on day 1 Maintenance Dose: ☐ Inject 200 mg every other week ☐ Inject 300 mg SC every other week ☐ Other	☐ 30 day supply ☐ 90 day supply ☐ Other	
Kitabis Pak	☐ 300 mg/5ml ampule	☐ Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug ☐ Other	☐ 4 week supply	

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

Physician Signature: _____ Date: _____

Pulmonology

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/NPA #: _____

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:
Perforomist	☐ 20mcg/2ml vial	☐ 20 mcg (one 2 mL unit) inhaled via Nebulization twice daily, in the morning and evening		
Pulmozyme	☐ 2.5 mg ampule ☐ 1mg/ml ampule	☐ Administer contents of one ampule once daily ☐ Administer contents of one ampule twice daily ☐ Other	☐ 30 Ampules ☐ 60 Ampules	
Revatio	☐ 20 mg tablet ☐ 10mg/12.5 ml Single-Use Vial ☐ 10mg/ml when reconstituted	☐ Take 20 mg (One Tablet) three times a day ☐ Other	☐ _____ Day supply	
Tobi Podhaler	☐ 28mg capsules	☐ Inhale contents of four capsules (112 mg) twice daily using Podhaler device ☐ Other	☐ 28 day multipack ☐ Other	
Tobramycin	☐ 300 mg/5ml ampule	☐ Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug ☐ Other	☐ 4 week supply	
Xolair	☐ 75 mg/0.5 mL in a single-dose prefilled syringe ☐ 150 mg/mL solution in a single-dose prefilled syringe ☐ 150 mg lyophilized powder in a single-dose vial for reconstitution	☐ Inject ____ mg every 2 weeks ☐ Inject ____ mg 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: _____