



BEHAVIORAL HEALTH

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: _____

LOCATION OF ADMINISTRATION AND SHIPPING INFORMATION

Location of Administration: _____ Additional Shipping Instructions? Yes ☐ No ☐

NPI: _____ DEA: _____ If YES, please specify: _____

Address: _____ Suite: _____ **MEDICATION INSTRUCTIONS FOR PHARMACY**

City: _____ State: _____ Zip: _____ Is this medication a new start? Yes ☐ No ☐

Phone: _____ Fax: _____ If NO, please provide: _____

Date Needed for Medication: _____ Initiation Date: _____ Date of Last Dose: _____

MEDICATION INFORMATION

☐ Abilify Maintena

☐ Invega Sustenna

☐ Sublocade*

☐ Aristada

☐ Olanzapine

☐ Vivitrol (naltrexone IM)

☐ Haloperidol deconate

☐ Risperdal

☐ Other: _____

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

* Prescribers must comply with their state-specific controlled substance prescribing requirement

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