NOBLE HEALTH SERVICES

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	PROVIDER INFORMATION
Patient Name: _____ ☐ Male	Prescriber's Name: _____
Street Address: _____ ☐ Female	Office Contact Name: _____
City: _____ State: _____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: _____ Zip Code: _____
Email Address: _____	Phone Number: _____
Last Four of Social: _____ Date of Birth: _____	Fax Number: _____
Translator Needed: ☐ Yes ☐ No Language: _____	DEA/NPI #: _____

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

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Medications Failed: _____

Medications On: _____

Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Actemra®	☐ 162mg/0.9ml prefilled syringe ☐ 162mg/0.9ml ACTPen autoinjector ☐ 80mg/4ml vial ☐ 200mg/10ml vial ☐ 400mg/20ml vial	☐ Inject _____ SC every other week ☐ Inject _____ SC every week Loading Dose: ☐ 4mg/kg (___ mg dose) every 4 weeks Maintenance Dose: ☐ 8mg/kg (____mg dose) every 4 weeks	☐ 4-week supply	
Cimzia®	☐ 200mg/ml prefilled syringe ☐ Starter Kit	Loading Dose: ☐ Inject 400mg SC at weeks 0, 2, and 4 Maintenance Dose: ☐ Inject 200mg SC every other week ☐ Inject 400mg SC every 4 weeks ☐ Other	☐ 4-week supply	
Cosentyx ® *Enhanced Specialty Pharmacy Program Participant	☐ 150mg pen ☐ 150mg syringe	Loading Dose: ☐ Inject 150mg at weeks 0, 1, 2, 3, 4 ☐ Inject 300mg at weeks 0, 1, 2, 3, 4 Maintenance Dose: ☐ Inject 150mg every 4 weeks ☐ Inject 300mg every 4 weeks	☐ 5-week supply (loading) ☐ 4-week supply (maintenance)	
Cosentyx ® *Enhanced Specialty Pharmacy Program Participant ***Covered Until You're Covered***	☐ 150mg pen ☐ 150mg syringe	Loading Dose: ☐ Inject 150mg at weeks 0, 1, 2, 3, 4 ☐ Inject 300mg at weeks 0, 1, 2, 3, 4 Maintenance Dose: ☐ Inject 150mg every 4 weeks ☐ Inject 300mg every 4 weeks	☐ 5-week supply (loading) ☐ 4-week supply (maintenance)	

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

Physician Signature: _____ Date: _____

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Delivery Needed By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other: _____

PATIENT INFORMATION	PROVIDER INFORMATION
Patient Name: _____ ☐ Male	Prescriber's Name: _____
Street Address: _____ ☐ Female	Office Contact Name: _____
City: _____ State: _____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: _____ Zip Code: _____
Email Address: _____	Phone Number: _____
Last Four of Social: _____ Date of Birth: _____	Fax Number: _____
Translator Needed: ☐ Yes ☐ No Language: _____	DEA/NPI #: _____

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CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Has the patient been treated previously for this condition?
☐ Yes ☐ No

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Medications Failed: _____

Medications On: _____

Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Cuprimine® penicillamine	☐ 250mg capsules	☐ Take 250mg by mouth four times a day ☐ Other	☐ 120 capsules	
Depen penicillamine	☐ 250mg titratable tablets	☐ Take 250mg by mouth four times a day ☐ Other	☐ 120 capsules	
Enbrel® **Enbrel® Mini Available**	Standard: ☐ 25mg/0.5ml prefilled syringe ☐ 50mg/ml single-use prefilled syringe ☐ 50mg/ml SureClick Autoinjector ☐ 25mg vial Mini: ☐ 50mg Enbrel® Mini single-dose prefilled cartridge	☐ Inject 50mg SC twice a week (72-96 hours apart) ☐ Inject 50mg SC once a week ☐ Inject 25mg SC twice a week (72-96 hours apart) ☐ Other	☐ 4-week supply	
Humira® **(Citrate-Free)**	☐ 40mg/0.4ml pen ☐ 40mg/0.4ml prefilled syringe	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once a week	☐ 4-week supply	
Inflectra®	☐ 100mg vial	Loading Dose: ☐ 5mg/kg (Dose____ mg) IV at 0, 2 and 6 weeks then every 8 weeks thereafter Maintenance Dose: ☐ 5mg/kg (Dose ____mg) IV every 8 weeks	☐ _____ vials	
Kevzara®	Prefilled Syringe: ☐ 150mg/1.14ml ☐ 200mg/1.14ml Prefilled Pen: ☐ 150mg/1.14ml ☐ 200mg/1.14ml	☐ Inject _____ mg once every two weeks	☐ 4-week supply	

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

Physician Signature: _____ Date: _____

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Delivery Needed By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other: _____

PATIENT INFORMATION	PROVIDER INFORMATION
Patient Name: _____ ☐ Male	Prescriber's Name: _____
Street Address: _____ ☐ Female	Office Contact Name: _____
City: _____ State: _____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: _____ Zip Code: _____
Email Address: _____	Phone Number: _____
Last Four of Social: _____ Date of Birth: _____	Fax Number: _____
Translator Needed: ☐ Yes ☐ No Language: _____	DEA/NPI #: _____

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CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Has the patient been treated previously for this condition?
☐ Yes ☐ No

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Medications Failed: _____

Medications On: _____

Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Olumiant®	☐ 2mg tablet	☐ Take one tablet (2mg) by mouth once daily	☐ 4-week supply	
Orencia®	☐ 250mg vial ☐ 125mg/ml syringe ☐ 125mg/ml ClickJect™ ☐ 50mg syringe (for children >2 years and weight 10kg to <25 kg)	IV Dosing: ☐ Infuse ____ mg at weeks 0,2,4 and every 4 weeks thereafter Subcutaneous Dosing: ☐ Inject 125mg SC once a week	☐ 4-week supply	
Otezla®	☐ Starter Kit ☐ 30mg	Starter Kit: ☐ Take as directed Maintenance Dose: ☐ Take 30mg twice daily	☐ Starter Kit ☐ 4-week supply	
Otrexup	Autoinjector: ☐ 10mg/0.4ml ☐ 12.5mg/0.4ml ☐ 15mg/0.4ml ☐ 17.5mg/0.4ml ☐ 20mg/0.4ml ☐ 22.5mg/0.4ml ☐ 25mg/0.4ml	☐ Inject _____ mg SC once weekly ☐ Other	☐ 4-week supply	
Rasuvo®	Autoinjector: ☐ 7.5mg/0.15ml ☐ 10mg/0.2ml ☐ 12.5mg/0.25ml ☐ 15mg/.3ml ☐ 17.5mg/0.35ml ☐ 20mg/0.4ml ☐ 22.5mg/0.45ml ☐ 25mg/0.5ml ☐ 27.5mg/0.55ml ☐ 30mg/0.6ml	☐ Inject _____mg SC once weekly ☐ Other	☐ 4-week supply	

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

Physician Signature: _____ Date: _____

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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: _____
Translator Needed: ☐ Yes ☐ No Language: _____

PROVIDER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Fax Number: _____
DEA/NPI #: _____

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CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?
☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Rayos®	☐ 1mg tablet ☐ 2mg tablet ☐ 5mg tablet	☐ Take _____mg by mouth once per day ☐ Other	☐ 4-week supply	
Remicade®	☐ 100mg vial	Loading Dose: ☐ IV _____ mg at 0, 2 and 6 weeks Maintenance Dose: ☐ IV _____ every 8 weeks ☐ IV _____ every_____ weeks ☐ Other	☐ _____ vials	
Renflexis®	☐ 100mg vial	Loading Dose: ☐ 5mg/kg (Dose ____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter Maintenance Dose: ☐ 5mg/kg (Dose ____ mg) IV every 8 weeks ☐ Other	☐ _____ vials	
Rinvoq™ ***AbbVie has contracted with Noble Health Services to provide product specific support.***	☐ 15mg tablet	☐ Take one tablet by mouth once daily	☐ 30-day supply	
Rituxan®	☐ 100mg/10ml vial ☐ 500mg/50ml vial	☐ Specified:	☐ _____ vials	

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Physician Signature: _____ Date: _____

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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: _____
Translator Needed: ☐ Yes ☐ No Language: _____

PROVIDER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Fax Number: _____
DEA/NPI #: _____

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CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?
☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Simponi®	Prefilled Syinge: ☐ 50mg/0.5ml ☐ 100mg/1ml SmartJect Autoinjector: ☐ 50mg/0.5ml ☐ 100mg/1ml	☐ Inject 100 mg SC once a month ☐ Inject 50 mg SC once a month	☐ 4-week supply	
Simponi Aria®	☐ 50mg/4ml single-dose vial	Loading Dose: ☐ _____ mg (2mg/kg) IV infusion over 30 min at weeks 0 and 4 Maintenance Dose: ☐ _____mg (2mg/kg) IV infusion over 30 min every 8 weeks	☐ _____ vials	
Skyrizi™	☐ 150mg/mL prefilled syringe ☐ 150mg/mL pen	Loading Dose: ☐ Inject 150mg SC at weeks 0, 4, and every 12 weeks thereafter Maintenance Dose: ☐ Inject 150mg SC every 12 weeks	☐ 1 prefilled syringe/pen	
Taltz®	☐ 80mg/ml single-dose prefilled autoinjector ☐ 80mg/ml single-dose prefilled syringe	**Psoriatic Arthritis & Ankylosing Spondylitis** Loading Dose: ☐ Inject 160mg subcutaneously at week zero Maintenance Dose: ☐ Inject 80 mg subcutaneously every 4 weeks **Non-radiographic Axial Spondyloarthritis** ☐ Inject 80mg subcutaneously every 4 weeks	☐ _____ pens ☐ _____ syringes	

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

Physician Signature: _____ Date: _____

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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: _____

Translator Needed: ☐ Yes ☐ No Language: _____

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

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Tremfya®	☐ 100mg/ml prefilled syringe ☐ 100mg/ml prefilled autoinjector	Loading Dose: ☐ Inject 100mg SC at weeks 0, 4, and every 8 weeks thereafter Maintenance Dose: ☐ Inject 100mg SC every 8 weeks	☐ 4 week supply (loading) ☐ 8 week supply (maintenance)	
Xeljanz®	☐ 5mg tablet	☐ Take one tablet twice a day	☐ 4-week supply	
Xeljanz XR®	☐ 11 mg tablet	☐ Take one tablet once a day	☐ 4-week supply	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____