OSTEOARTHRITIS

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: ______________

Has the patient been treated previously for this condition?

☐ Yes ☐ No

ICD-10 Code: ______________

Height: ________ft ________ ins Weight: ________ lbs

Medications Failed: ______________

Allergies: ______________

Medications On: ______________

Other Notes: ______________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Duexis	☐ 800mg/26.6mg tablet	☐ Take 1 tablet ___ time(s) a day	☐ _____ day supply	
Euflexxa	☐ 20mg/2ml prefilled syringe	☐ Inject contents of prefilled syringe intraarticularly once a week for three weeks Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ prefilled syringes	
Gel-One®	☐ 30mg/3ml prefilled syringe	☐ Inject contents of prefilled syringe intraarticularly one time Patient to use: ☐ Unilaterally ☐ Bilaterally		
Genvisc 850	☐ 2.5ml prefilled syringe	☐ Inject contents of prefilled syringe intraarticularly once a week for 5 weeks Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ prefilled syringes	
Hyalgan	☐ 20mg/2ml prefilled syringe ☐ 30mg/2ml vial	☐ Inject contents of prefilled syringe intra-articularly once a week for five weeks Patient to use: ☐ Unilaterally ☐ bilaterally	☐ _____ prefilled syringes ☐ _____ vials	
Monovisc	☐ 88mg/4ml prefilled syringe	☐ Inject contents of prefilled syringe intraarticularly one time Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ ____ prefilled syringes	

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration ☐ Include one 20G 1.5" needle per syringe

Physician Signature: ______________________ Date: ______________________

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

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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: ____________
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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

Medications Failed: ____________

Allergies: ____________

Medications On: ____________

Other Notes: ____________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Orthovisc	☐ 30mg/2ml prefilled syringe	☐ Inject contents of prefilled syringe intraarticularly once a week for____ weeks Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ prefilled syringes	
Pennsaid	☐ 40mg/2% pump	☐ Dispense 40mg (2 pump actuations) directly onto knee or first into hand then onto knee	☐ ______ pumps	
Provisc				
Supartz	☐ 25mg/2.5ml	☐ Inject contents of prefilled syringe intraarticularly once a week for five weeks Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ prefilled syringes	
Synvisc	☐ 16mg/2.5ml	☐ Inject contents of prefilled syringe/intraarticularly once a week for three weeks Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ prefilled syringes	
Synvisc One	48mg/6ml prefilled syringe	☐ Inject contents of prefilled syringe/ intraarticularly one time Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ prefilled syringes	
Vimovo	☐ 375/20 500/20 delayed-release tablets	☐ Take one tablet ____ time(s) a day	☐ ______ day supply	
Other				

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration ☐ Include one 20G 1.5" needle per syringe

Physician Signature: ____________ Date: ____________

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