E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ NOBLE NORTHEAST Tel: 888-843-2040 Fax: 888-842-3977
☐ NOBLE SOUTHEAST Tel: 866-420-4041 Fax: 601-420-4040

Pulmonology

Delivery Need By: _________ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other __________

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ____________ ☐ Male	Prescriber's Name: ____________
Address: ____________ ☐ Female	Office Contact Name: ____________
City: ________ State: ______ Zip: ______	Address: ____________
Phone Number: ____________	City: ________ State: ______ Zip: ______
Email Address: ____________	Phone: ________ Fax: ________
Last Four of Social: ________ DOB: ________	DEA/NPI#: ____________

INSURANCE – PLEASE FAX 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 ______ inches Weight: ______ lbs	Medications Failed: ____________
Last PPD Test: ☐ Positive ☐ Negative Date: ________	Medications On: ____________
Allergies: ____________	Other Notes: ____________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Adcirca® (tadalafil)	☐ 20 mg tablet	☐ Take 40 mg (2 tablets) once a day ☐ Other	☐ _____ day Supply	
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	
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 ☐ 90 day supply	
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 (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	
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: ______________

Important Notice: *This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy.*

V.Q220201

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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: ______________________ Fax: ___________________
DEA/NPI#: ________________________________

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CLINICAL INFORMATION

Diagnosis: ____
ICD-10 Code: ____
Height: _______ ft _______ inches Weight: _______ lbs
Last PPD Test: ☐ Positive ☐ Negative Date: _________
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® (sildenafil)	☐ 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	
Tobi®	☐ 300 mg/5 ml 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		
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				

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

Physician Signature: ____________________________________ Date: __________________________

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