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**

Rheumatology

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/NPI #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

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:
Actemra®	☐ 162mg/0.9ml Prefilled syringe ☐ 162 mg/0.9ml ACTPen autoinjector	☐ Inject 162 mg SC every OTHER week ☐ Inject 162 mg SC every week	☐ 4 week supply ☐ Other	
	☐ 80 mg/4ml Vial ☐ 200mg/10ml Vial ☐ 400mg/20ml Vial	Loading Dose: ☐ Infuse 4mg/kg (_____mg dose) via IV every 4 weeks Maintenance Dose: ☐ Infuse 8 mg/kg (_____mg dose) via IV every 4 weeks.		
Cimzia®	☐ 200 mg/ml Prefilled SYR ☐ Starter Kit	Loading Dose: ☐ Inject 400 mg SC at weeks 0, 2 and 4 Maintenance Dose: ☐ Inject 200 mg SC every other week ☐ Inject 400 mg SC every 4 weeks	☐ 4 week supply ☐ Other	
Cosentyx® **Enhanced Specialty Pharmacy Program Participant*	☐ 150 mg Pen ☐ 150 mg SYR	Loading Dose: ☐ Inject 150 mg at weeks 0, 1, 2, 3, 4 ☐ Inject 300 mg at weeks 0, 1, 2, 3, 4 Maintenance Dose: ☐ Inject 150 mg every 4 weeks ☐ Inject 300 mg every 4 weeks	☐ 5 week supply (loading) ☐ 4 week supply (loading) ☐ Other	
Cosentyx® **Enhanced Specialty Pharmacy Program Participant* ***Covered Until You're Covered***	☐ 150 mg Pen ☐ 150 mg SYR	Loading Dose: ☐ Inject 150 mg at weeks 0, 1, 2, 3, 4 ☐ Inject 300 mg at weeks 0, 1, 2, 3, 4 Maintenance Dose: ☐ Inject 150 mg every 4 weeks ☐ Inject 300 mg every 4 weeks	☐ 5 week supply (loading) ☐ 4 week supply (loading) ☐ Other	
Enbrel® ***Enbrel® Mini Available***	Standard: ☐ 25mg/0.5ml Prefilled SYR ☐ 50mg/ml Single Use Prefilled SYR ☐ 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 ☐ Other	
Humira® Citrate-Free	☐ 40mg/0.4 ml Pen ☐ 40 mg/0.4 ml Prefilled SYR	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC once a week ☐ Other	☐ 4 week supply ☐ Other	

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

v. Q120201g

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

Rheumatology

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/NPI #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

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:
Inflectra®	☐ 100 mg vial	Loading Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV at 0, 2 and 6 weeks Maintenance Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV every 8 weeks	☐ _____ # of 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 ☐ Other	
Olumiant®	☐ 2 mg tablet	☐ Take one tablet (2mg) by mouth once daily	☐ 4 week supply ☐ Other	
Orencia®	☐ 250mg Vial ☐ 125mg/ml SYR ☐ 125mg/ml Clickject ☐ 50 mg SYRINGE (for children ≥ 2years and weighing 10kg to less than 25kg	IV Dosing: ☐ Infuse _____ mg at weeks 0, 2, 4 and every 4 weeks thereafter Subcutaneous Dosing: ☐ Inject 125 mg subcutaneously once a week ☐ Other	☐ 4 week supply ☐ Other	
Otezla®	☐ Starter Kit ☐ 30 mg	Starter Kit: ☐ Take as directed Maintenance Dose: ☐ Take 30 mg twice daily		
Otrexup	Autoinjector: ☐ 10 mg / 0.4 ml ☐ 20mg/ 0.4 ml ☐ 12.5 mg/ 0.4 ml ☐ 22.5mg/ 0.4 ml ☐ 15mg/ 0.4 ml ☐ 25mg/ 0.4 ml ☐ 17.5mg/ 0.4 ml	☐ Inject _____ mg subcutaneously once weekly ☐ Other	☐ 4 week supply ☐ Other	
Rasuvo®	Autoinjector: ☐ 7.5 mg/0.15ml ☐ 20 mg/0.4ml ☐ 10 mg/0.2ml ☐ 22.5 mg/0.45ml ☐ 12.5 mg/0.25ml ☐ 25 mg/0.5ml ☐ 15 mg/.3ml ☐ 27.5 mg/0.55ml ☐ 17.5 mg/0.35ml ☐ 30 mg/0.6ml	☐ Inject _____ mg subcutaneously once weekly ☐ Other	☐ 4 week supply ☐ Other	
Rayos®	☐ 1 mg tablet ☐ 2 mg tablet ☐ 5 mg tablet	☐ Take _____ mg by mouth once per day ☐ Other	☐ 4 week supply ☐ Other	
Remicade	☐ 100mg vial	Loading Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV at 0, 2 and 6 weeks Maintenance Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV every 8 weeks ☐ Infuse _____ mg every _____ weeks ☐ Other	☐ _____ # of vials	

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

Physician Signature: _____ Date: _____

v. Q120201g

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

Rheumatology

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/NPI #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

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:
Renflexis®	☐ 100mg vial	Loading Dose: ☐ Infuse 5mg/kg (Dose _____mg) via IV at 0, 2 and 6 weeks, then every 8 weeks thereafter Maintenance Dose: ☐ Infuse 5mg/kg (Dose _____mg) IV every 8 weeks ☐ IV _____ mg every _____ weeks	☐ _____ # of Vials	
Rinvoq ™ *AbbVie has contracted with Noble Health Services to provide product-specific support.*	☐ 15 mg tablet	☐ Take one tablet by mouth once daily	☐ 30 day supply ☐ Other	
Rituxan®	Vial: ☐ 100 mg/10ml ☐ 500 mg /50ml	☐ Specified:	☐ _____ # of vials	
Simponi®	Prefilled Syringe: ☐ 50ml/0.5ml ☐ 100mg/1ml SmartJect AutoInjector: ☐ 50ml/0.5ml ☐ 100mg/1ml	☐ Inject 100 mg subcutaneously once a month ☐ Inject 50 mg subcutaneously once a month	☐ 4 week supply ☐ Other	
Simponi Aria®	☐ 50mg/4ml single dose vial	Loading Dose: ☐ Infuse 2mg/kg (Dose ____ mg) via IV over 30 minutes at weeks 0 and 4 Maintenance Dose: ☐ Infuse 2mg/kg (Dose ____ mg) via IV over 30 minutes every 8 weeks		
Taltz®	☐ 80 ml/ml single-dose prefilled autoinjector ☐ 80mg/ml single-dose prefilled syringe	Loading Dose: ☐ Inject 160mg subcutaneously at week zero Maintenance Dose: ☐ Inject 80mg subcutaneously every 4 weeks	☐ ____ pens ☐ ____ syringes ☐ Other	
Xeljanz®	☐ 5 mg tablet	☐ Take one tablet twice a day	☐ 4 week supply ☐ Other	
Xeljanz XR®	☐ 11 mg tablet	☐ Take one tablet once a day	☐ 4 week supply ☐ Other	
Other				

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

Physician Signature: _____ Date: _____

v. Q120201g