



## ASTHMA AND ALLERGY

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: \_\_\_\_\_

### MEDICATION INFORMATION

☐ Cinqair® ☐ Dupixent® ☐ Firazyr® ☐ Xolair® ☐ Other: \_\_\_\_\_

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

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