NEUROLOGY

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

Medications Failed: ____________

Allergies: ____________

Medications On: ____________

Other Notes: ____________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Aubagio®	☐ 7mg ☐ 14mg	☐ Take one tablet once a day ☐ Other	☐ 28-day supply	
Austedo® deutetrabenazine	☐ 6mg tablet ☐ 9mg tablet ☐ 12mg tablet	☐ ______ mg by mouth once daily ☐ ______ mg by mouth twice daily ☐ Other	☐ 7-day supply ☐ 30-day supply	
Avonex®	☐ 30mcg vial ☐ 30mcg syringe ☐ 30mcg pen	☐ Inject 30mcg intramuscularly once a week	☐ 30-day supply	
Betaseron®	☐ 0.3mg vial	☐ Inject .25mg (1ml) SC every other day ☐ Other	☐ 28-day supply	
Botox®	☐ 100U ☐ 200U	☐ Inject ____ units as directed	☐ ______ vials	
Copaxone®	☐ 20mg/ml ☐ 40mg/ml	☐ Inject 20mg SC daily ☐ Inject 40mg SC three times a week ☐ Other	☐ ____-day supply	
dalfampridine	☐ 10mg extended-release tablet	☐ Take one tablet twice daily every 12 hours ☐ Other	☐ 30-day supply	
Elaprase®	☐ 6mg/3ml	☐ Specified:		
Extavia	☐ 0.3mg single-dose vial	☐ Inject .25mg (1ml) SC every other day ☐ Other	☐ 28-day 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: ____________________

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:
Gilenya®	☐ 0.5mg tablet	☐ Take one capsule once a day ☐ Other	☐ 30-day supply	
glatiramer acetate injection	☐ 20mg/ml prefilled syringe ☐ 40mg/ml prefilled syringe	☐ Inject 20mg/ml (1 syringe) SC once a day ☐ Inject 40mg/ml (1 syringe) SC three times a week and at least 48 hours apart ☐ Other	☐ ____ prefilled syringes	
Glatopa®	☐ 20mg/ml prefilled syringe ☐ 40mg/ml prefilled syringe	☐ Inject 20mg/ml (1 syringe) SC once a day ☐ Inject 40mg/ml (1 syringe) SC three times a week and at least 48 hours apart ☐ Other	☐ ____ prefilled syringes	
Kesimpta®	☐ 20mg/0.4ml prefilled pen	Loading Dose: ☐ Inject 20mg SC at weeks 0,1,2 Maintenance Dose: ☐ Inject 20mg SC monthly starting at week 4	☐ ____-day supply	
Mayzent®	☐ 0.25mg tablet ☐ 2 mg dose starter pack ☐ 2 mg tablet	☐ 1mg Dose Titration Schedule: **Days 1-2**: 1x 0.25mg tab by mouth **Day 3:** 2x 0.25mg tab by mouth **Day 4:** 3x 0.25mg tab by mouth **Day 5:** 4x 0.25mg tab by mouth ☐ 1mg Dose Maintenance Schedule: **Day 6+:** 4x 0.25mg tab by mouth once daily ☐ 2mg Dose Titration Schedule: **Days 1-2**: 1x 0.25mg tab by mouth **Day 3:** 2x 0.25mg tab by mouth **Day 4:** 3x 0.25mg tab by mouth **Day 5:** 5x 0.25mg tab by mouth ☐ 2mg Dose Maintenance Schedule: **Day 6+:** 1x 2mg tab by mouth once daily ☐ Other	☐ ____-day 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: ____________

Has the patient been treated previously for this condition?

ICD-10 Code: ____________

☐ Yes ☐ No

Height: ________ ft ________ ins Weight: ________ lbs

Medications Failed: ____________

Allergies: ____________

Medications On: ____________

Other Notes: ____________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Novantrone	☐ 20mg/10ml ☐ 25mg/12.5ml ☐ 30mg/15ml	☐ _______ mg (12 mg/m^2) IV every 3 months ☐ Other		
Nurtec	☐ 75mg orally disintegrating tablet	☐ Take 1 tablet (75mg) by mouth once daily AS NEEDED for ACUTE treatment of migraine. Not to exceed 18 doses per month. ☐ Take 1 tablet (75mg) by mouth once every other day for PREVENTION of episodic migraine. Not to exceed 18 doses per month.	☐ ______ tablets	
Ocrevus®	☐ 300mg/10ml single-dose vial	Loading Dose: ☐ 300mg IV infusion, followed 2 weeks later by a second 300mg IV infusion Maintenance Dose: ☐ 600mg IV infusion every 6 months **Each dose must be diluted prior to administration*	☐ ______ vials	
Plegridy®	☐ Starter Pack (63mcg and 94mcg) Prefilled Syringes ☐ Starter Pack (63mcg and 94mcg) Autoinjectors ☐ 125mcg/0.5ml prefilled syringe ☐ 125mcg/0.5ml autoinjector	Loading Dose: ☐ Inject 63 mcg SC once on day 1, inject 94mcg SC on day 15, then inject 125mcg SC on day 29 and every 2 weeks thereafter Maintenance Dose: ☐ Inject 125mcg SC every 2 weeks		
Qulipta	☐ 10mg tablet ☐ 30mg tablet ☐ 60mg tablet	☐ Take ____mg by mouth once daily	☐ 30-day supply ☐ 90-day supply	
Rebif®	☐ 22 mcg prefilled syringe ☐ 44 mcg prefilled syringe	☐ Inject _____ mcg SC three times a week ☐ Other		

☐ 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: ____________

Has the patient been treated previously for this condition?

ICD-10 Code: ____________

☐ Yes ☐ No

Height: ________ft ________ ins Weight: ________ lbs

Medications Failed: ____________

Allergies: ____________

Medications On: ____________

Other Notes: ____________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Rebif® Rebidose	☐ 44 mcg/0.5ml prefilled syringe	☐ Inject 44mcg subcuteanously three times a week ☐ Other		
Rebif® Rebidose Titration	☐ 8.8mcg/0.2ml-22mcg/0.5ml	☐ Titration Schedule: **Weeks 1-2**: 4.4mcg (0.1ml) SC three times a week **Weeks 3-4:** 11mcg (0.25ml) SC three times a week **Week 5+:** 22mcg (.5ml) SC three times a week ☐ Titration Schedule: **Week 1-2:** 8.8mcg (0.1ml) SC three times a week **Week 3-4:** 22mcg (0.25ml) SC three times a week **Week 5+:** 44mcg (.5ml) SC three times a week ☐ Other	☐ 30-day supply	
Rebif® Syringe Titration	☐ 8.8mcg/0.2ml-22mcg/0.5ml	☐ Titration Schedule: **Weeks 1-2**: 4.4mcg (0.1ml) SC three times a week **Weeks 3-4:** 11mcg (0.25ml) SC three times a week **Week 5+:** 22mcg (.5ml) SC three times a week ☐ Titration Schedule: **Week 1-2:** 8.8mcg (0.1ml) SC three times a week **Week 3-4:** 22mcg (0.25ml) SC three times a week **Week 5+:** 44mcg (.5ml) SC three times a week ☐ Other		
Tecfidera® dimethyl fumarate ***Generic Only***	☐ 120mg delayed-release capsule ☐ 240mg delayed-release capsule	☐ Take 120mg by mouth twice daily for seven days ☐ Take 240mg by mouth twice daily ☐ Other	☐ 14 capsules ☐ _____-day supply	

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

Physician Signature: ____________________ Date: ____________________

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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: __________ Fax Number: __________
Last Four of Social: __________ Date of Birth: __________	DEA/NPI #: ______________

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CLINICAL INFORMATION

Diagnosis: ______________________

Has the patient been treated previously for this condition?

ICD-10 Code: ______________________

☐ Yes ☐ No

Height: ________ ft __________ ins Weight: ________ lbs

Medications Failed: ______________________

Allergies: ______________________

Medications On: ______________________

Other Notes: ______________________

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Xenazine® tetrabenazine ***Generic Only***	☐ 12.5mg tablet ☐ 25mg tablet	☐ ______ mg by mouth once daily ☐ ______ mg by mouth twice daily ☐ Other	☐ 7-day supply ☐ 30-day supply	
vigabatrin	☐ 500mg packet - powder for solution formulation only	☐ ______ mg by mouth twice a day	☐ ______ packets	
Zeposia	☐ 7-day Starter Pack (4 capsules of 0.23mg and 3 capsules of 0.46mg) ☐ Starter Kit (4 capsules of 0.23mg, 3 capsules of 0.46mg, and 1 bottle containing 30 capsules of 0.92mg) ☐ 0.92mg capsules	☐ Take 0.23mg capsule by mouth once daily on days 1-4, then 0.46mg capsule once daily on days 5-7 ☐ Take 0.23mg capsule by mouth once daily on days 1-4, then 0.46mg capsule once daily on days 5-7, then 0.92mg capsule once daily starting on day 8 ☐ Take 0.92mg capsule by mouth once daily	☐ 1 Starter Pack (7-day supply) ☐ 1 Starter Kit (37-day supply) ☐ 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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