E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE NEW YORK**
Tel: 888-843-2040
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Hepatitis B

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

Allergies: _____

Viral Load: _____ Genotype: _____

Metavir Fibrosis Score: _____

Has the patient been treated previously for this condition?
☐ Yes ☐ No

Cirrhosis: ☐ Yes ☐ No
If yes, Decompensated? ☐ Yes ☐ No
Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Baraclude®	☐ 0.5 mg tablet ☐ 1mg tablet ☐ 0.05mg/ml	☐ Take one 0.5mgtablet by mouth daily ☐ Take one 1 mg tablet by mouth daily ☐ Take _____ ml by mouth daily	☐ 30 day supply ☐ Other	
Epivir HBV	☐ 100mg tablet ☐ 5 mg/ml solution	☐ Take one 100 mg tablet by mouth daily ☐ Take _____ ml by mouth daily	☐ 30 Day Supply ☐ Other	
Hepsera®	☐ 10mg tablet	☐ Take one 10 mg tablet by mouth daily	☐ 30 Day Supply	
Intron-A	☐ 10 million unit powder for injection ☐ 25 million unit solution for injection			
Pegasys®	☐ 180 mcg/ml single dose vial ☐ 180 mcg/0.5 ml prefilled syringe ☐ 180 mcg/0.5 ml autoinjector ☐ 180 mcg/0.5 ml autoinjector	☐ Inject 180 mcg subcutaneously once weekly ☐ Other	☐ 28 day supply ☐ Other	
Vemlidy®	☐ 25 mg tablet	☐ Take one 25 mg by mouth daily with food	☐ 30 day supply	
Viread®	☐ 300 mg tablet	☐ Take one 300 mg tablet by mouth daily ☐ Other	☐ 30 day supply	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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