Autoimmune Enrollment Form Medications A-M



□ Noble Syracuse Phone: (888) 843-2040 Fax: (888) 842-3977 □ Noble Mississippi Phone: (866) 420-4041 Fax: (601) 420-4040

www.noblehealthservices.com

Signature Care Program

Delivery Need By:

Delivery to: Patients Home Physician's Office Other

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Patient Name:		Female Male	Prescriber Name:		
Address:			Address:		
City, State, Zip:			City, State, Zip:		
Phone:			Phone:		
Date of Birth:			Fax:		
Last Four of Social Security Number:			DEA/NPI#:		
	INSURANCE – P	LEASE FAX COPY OF	PRESCRIPTION CARD FROM	NT & BACK	
		CLINICAL IN	IFORMATION		
Diagnosis:			Has the patient been treated previously for this condition?		
ICD-10 Code:			Medications failed:		
Height: feet	Weight: inches Ibs.		Medications on:		
Allergies:			Other notes:		
		PRESCRIPTION	INFORMATION		
Medication:	Dosage/Strength:	Directions:		Quantity:	Refills:
Actemra®	162mg/0.9ml	SC every OTHER week SC every week Other:		4 week supply Other:	
Cimzia®	200mg/ml Prefilled SYR Starter Kit	Loading Dose: Inject 400mg SC at weeks 0,2 and 4	Maintenance Dose: 5 200mg SC every other week 400mg SC every 4 weeks	4 week supply	
Enbrel®	 50mg/ml Single Use Prefilled SYR 50mg/ml SureClick AutoInjector 25mg/0.5ml Prefilled SYR 25mg Vial 	 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®	 40mg/0.8ml Pen 40mg/0.8ml Prefilled SYR 40mg/0.4ml Pen (Citrate-Free) 40mg/0.4ml Prefilled SYR (Citrate-Free) Free) 	 Inject 40mg SC every OTHER week Inject 40mg SC ONCE a week 		4 week supply Other:	
Other:					
Patient is interested in patient support programs					ninistration

Office Contact Name: ______ Preferred Phone Number & Extension: ______

Physician Signature:

Date:

E-Scribe Rx and Fax this Form

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Autoimmune Enrollment Form Medications N-Z



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Signature Care Program

Delivery Need By:

Delivery to: Patients Home Physician's Office Other

Orencia® 250mg Vial Infuse mg at weeks 0, 2, 4 then every 4 weeks thereafter 4 week supply 125mg/ml SYR Inject 125mg once a week Other: 0ther: 0ther: 0tezla® 30mg tablet 30mg TWICE daily 4 week supply 4 week supply 0tezla® 30mg Vial IV mg at 0, 2, and 6 weeks (induction) # of Vials Remicade® 100mg Vial IV mg at 0, 2, and 6 weeks (maintenance) # of Vials IV mg every weeks # of Vials # of Vials Simponi® 100mg/10ml Vial Specified: # of Vials Simponi® 100mg/10ml Prefilled SYR Inject 100mg SC ONCE a month 4 week supply AutoInjector Inject 50mg SC ONCE a month Other: 0 ther: Somg/0.5ml Prefilled SYR Inject mg at weeks 0, 4, then every 8 weeks thereafter Loading Dose/4 week supply Maintenance/8 week supply Maintenance/8 week supply Maintenance/8 week supply Xeljanz % Xeljanz % 11mg tablet Take one tablet once a day 4 week supply 4 week supply	PATIENT INFORMATION			PRESCRIBER INFORMATION			
City, State, Zip: City, State, Zip: Phone: Phone: Date of Birth: Phone: Date of Birth: Fax: Last Four of Social Security Number: DE/NP/#: DE/NP/#: INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK CLINICAL INFORMATION Diagnosis: INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK CLINICAL INFORMATION Diagnosis: INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK CLINICAL INFORMATION Diagnosis: INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK CLINICAL INFORMATION Diagnosis: INSURANCE - PLEASE FAX COPY OF PRESCRIPTION INFORMATION INSURANCE - PLEASE FAX COPY OF PRESCRIPTION INFORMATION INFORMATION Medications on: INFORMATION INFORMATION INFORMATION Medications on: INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION	Patient Name:			Prescriber Name:			
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Other:	Xeljanz®	5mg tablet	Twice Daily		4 week supply		
	Xeljanz XR®	11mg tablet	Take one tablet once a day		4 week supply		
	Other:						
Patient is interested in patient support programs	inistration						

Office Contact Name: ______ Preferred Phone Number & Extension: ______

Physician Signature:

Date:

E-Scribe Rx and Fax this Form

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