Autoimmune Enrollment Form
Medications A-M

www.noblehealthservices.com

NOBLE HEALTH SERVICES
A SPECIALTY PHARMACY

Signature Care Program

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

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 – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
ICD-10 Code:	Medications failed:
Height: feet inches Weight: lbs.	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: ☐ 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)**	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	☐ 4 week supply ☐ Other:	
Other:				

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

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

Physician Signature: _____ Date: _____

E-Scribe Rx and Fax this Form

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Medications N-Z

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ICD-10 Code:	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Orencia®	☐ 250mg Vial ☐ 125mg/ml SYR ☐ 125mg/ml Clickject	☐ Infuse mg at weeks 0, 2, 4 then every 4 weeks thereafter ☐ Inject 125mg once a week	☐ 4 week supply ☐ Other:	
Otezla®	☐ 30mg tablet ☐ Starter Kit	☐ 30mg TWICE daily ☐ Use Directions on Starter Kit ☐ Other:	☐ 4 week supply	
Remicade®	☐ 100mg Vial	☐ IV mg at 0, 2, and 6 weeks (induction) ☐ IV mg every 8 weeks (maintenance) ☐ IV every weeks	☐ # of Vials	
Rituxan®	☐ 100mg/10ml Vial ☐ 500mg/50ml Vial	Specified:	☐ # of Vials	
Simponi®	☐ 100mg/1ml SmartJect AutoInjector ☐ 100mg/1ml Prefilled SYR ☐ 50mg/0.5ml SmartJect AutoInjector ☐ 50mg/0.5ml Prefilled SYR	☐ Inject 100mg SC ONCE a month ☐ Inject 50mg SC ONCE a month	☐ 4 week supply ☐ Other:	
Tremfya®	☐ 100mg/ml Prefilled SYR	☐ Inject mg at weeks 0, 4, then every 8 weeks thereafter	☐ Loading Dose/ 4 week supply ☐ Maintenance/ 8 week supply	
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 ☐ Ancillary supplies provided for administration

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

Physician Signature: _____ Date: _____

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