NEPHROLOGY

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: ______________________

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:
Astagraf XL®	☐ .5mg ☐ 1mg ☐ 5mg			
Auryxia®	☐ 210mg tablet	☐ Take ___ tablet(s) by mouth three times per day with food ☐ Other	☐ 4-week supply ☐ 12-week supply ☐ Other	
CellCept®	☐ 200mg/ml ☐ 500mg ☐ 250mg			
Depen® Titratab penicillamine	☐ 250 mg tablet	☐ Take _____mg by mouth _______ times per day. Administer orally at least 1 hour before or 2 hours after meals and at least 1 hour before or after any other drug, food, or milk.	☐ 30-day supply ☐ 90-day supply	
Envarsus XR®	☐ .75mg ☐ 1mg ☐ 4mg			
Epogen®	Single Dose Vial: ☐ 2,000u/ml ☐ 3,000u/ml ☐ 4,000u/ml ☐ 10,000u/ml Multi Dose Vial: ☐ 20,000u/ml 1 ml vial ☐ 10,000 u/ml 2 ml vial	Single Dose Vial: ☐ Inject the entire contents of 1 vial SC once a a week ☐ Inject the entire contents of 1 vial SC three times a week Multi Dose Vial: ☐ Inject _____ ml (____ units) SC once a week ☐ Inject _____ ml (____ units) SC three times a week	☐ ____ single-dose vials ☐ ____ multi-dose vials	

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: ______________________ Date: ______________________

NATIONALLY ACCREDITED. **100% EMPLOYEE OWNED.**

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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: ____________
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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:
Gengraf	☐ 25mg ☐ 50mg ☐ 100mg			
Myfortic	☐ 180mg ☐ 360mg			
Neoral	☐ 25mg ☐ 100mg ☐ 100mg/ml			
Procrit	Single Dose Vial: ☐ 2,000u/ml ☐ 3,000u/ml ☐ 4,000u/ml ☐ 10,000u/ml Multi Dose Vial: ☐ 20,000u/ml 1 ml vial ☐ 10,000u/ml 2 ml vial	Single Dose Vial: ☐ Inject the entire contents of 1 vial SC once a a week ☐ Inject the entire contents of 1 vial SC three times a week Multi Dose Vial: ☐ Inject _____ ml (____ units) SC once a week ☐ Inject _____ ml (____ units) SC three times a week	☐ ____ single-dose vials ☐ ____ multi-dose vials	
Rapamune™	☐ .5mg ☐ 1mg ☐ 2mg ☐ 1mg/ml			
Retacrit®	Single Dose Vial: ☐ 2,000u/ml ☐ 3,000u/ml ☐ 4,000u/ml ☐ 10,000u/ml ☐ 40,000u/ml	Single Dose Vial: ☐ Inject the entire contents of 1 vial SC once a a week ☐ Inject the entire contents of 1 vial SC three times a week	☐ ____ single-dose vials	
Sandimmune®	☐ 25mg ☐ 100mg			

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

Physician Signature: ____________ Date: ____________

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Street Address: ______________ ☐ Female	Office Contact Name: ______________
City: __________ State: ____ Zip Code: ______	Address: ______________
Phone Number: ______________	City: __________ State: ____ Zip Code: ______
Email Address: ______________	Phone Number: ______________
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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:
Sensipar® cinacalcet	☐ 30mg tablet ☐ 60mg tablet	☐ Take ____ mg by mouth once daily with food ☐ Other	☐ 4-week supply ☐ 12-week supply	
Veltassa	☐ 8.4g packet ☐ 16.8g packet ☐ 25.2g packet	☐ Dissolve one packet into 1/3 cup of water and drink full amount once daily	☐ 30-day supply ☐ 90-day supply	
Zortress®	☐ .25mg ☐ .5mg			
Other				

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

Physician Signature: ______________________ Date: ______________________

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