HORMONAL THERAPIES

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:
Firmagon®	☐ 120mg vial ☐ 80mg vial	Initial Dose: ☐ Inject 240mg (2-120mg injections) SC Maintenance Dose: ☐ Inject 80mg SC every 28 days	☐ 4-week supply	
Lupaneta Pack™ leuprolide, norethindrone	☐ 3.75mg suspension for injection, 5mg tablet ☐ 11.25mg suspension for injection, 5mg tablet	☐ 3.75mg IM once monthly, 5mg tablet by mouth once daily ☐ 11.25mg IM once every 3 months, 5mg tablet by mouth once daily	☐ 1 pack	
Lupron Depot®	☐ 3.75mg suspension for injection ☐ 7.5mg suspension for injection ☐ 11.25mg suspension for injection ☐ 22.5mg suspension for injection ☐ 30mg suspension for injection ☐ 45mg suspension for injection	☐ ________mg IM once monthly ☐ ________mg IM once every 3 months ☐ ________mg once every 4 months ☐ ________mg once every 6 months	☐ 1 dose	
Supprelin® LA	☐ 50mg subcutaneous implant	☐ 1 implant inserted subcutaneously every 12 months	☐ 1 implant	
Trelstar®	☐ 3.75mg suspension for injection ☐ 11.25mg suspension for injection ☐ 22.5mg suspension for injection	☐ ________mg IM once monthly ☐ ________mg IM once every 3 months ☐ ________mg once every 6 months	☐ 1 dose	
Vantas™	☐ 50mg subcutaneous implant	☐ 1 implant inserted subcutaneously every 12 months	☐ 1 implant	
Zoladex®	☐ 3.6mg implant ☐ 10.8mg implant	☐ 3.6 mg subcutaneous into the upper abdominal wall every 28 days ☐ 10.8 mg subcutaneous into the upper abdominal wall once every 12 weeks ☐ Other	☐ 1 dose	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: ______________ Date: ______________

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