NOBLE HEALTH SERVICES

ENDOCRINOLOGY

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: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Afrezza®	☐ Titration Pack - (4 & 8 unit) ☐ Titration Pack - (4, 8, & 12 unit) ☐ 4-unit cartridge ☐ 8-unit cartridge ☐ 12-unit cartridge	☐ Administer using a single inhalation per cartridge at beginning of a meal		
Sandostatin®	Ampules: ☐ 50mcg/ml ☐ 100mcg/ml ☐ 500mcg/ml Multi-Dose Vial: ☐ 200mcg/ml (5ml) ☐ 1000mcg/ml (5ml)	☐ Administer _____ mcg subcutaneously three times a day ☐ Other	☐ 4-week supply ☐ 12-week supply	
Sandostatin® LAR	☐ 10mg vial kit ☐ 20mg vial kit ☐ 30mg vial kit	☐ Administer _____mg intragluteally every 4 weeks (Mix the contents of vial with diluent) ☐ Other	☐ 4-week supply ☐ 12-week supply	
Sensipar®	☐ 30mg tablet ☐ 60mg tablet ☐ 90mg tablet	☐ Take ____ mg by mouth once daily with food ☐ Other	☐ 4-week supply ☐ 12-week supply	
Somatuline® Depot	☐ 60mg prefilled syringe ☐ 90mg prefilled syringe ☐ 120mg prefilled syringe	☐ Inject _____mg by deep subcutaneous injection every 4 weeks	☐ 4-week supply ☐ 12-week supply	
Tymlos®	☐ 2000mcg/ml, 1.5 ml pen	☐ Inject 80mcg SC once daily	☐ 1 device (30-day supply) ☐ 3 devices (90-day supply)	
31G Pen Needles	☐ 5mm ☐ 6mm ☐ 8mm	☐ Use with Tymlos® as directed	☐ 30-day supply ☐ 90-day supply	

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

Physician Signature: _____ Date: _____

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

www.noblehealthservices.com