



UROLOGY

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

Patient Name: _____ Male
Street Address: _____ Female
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ Date of Birth: _____
Translator Needed: Yes No Language: _____

PROVIDER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Fax Number: _____
DEA/NPI #: _____

INSURANCE - PLEASE FAX A COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____ Has the patient been treated previously for this condition?
ICD-10 Code: _____ Yes No
Height: _____ ft _____ ins Weight: _____ lbs Medications Failed: _____
Allergies: _____ Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

| Medication: | Dosage/Strength: | Directions: | Quantity: | Refills: |
|-------------------|---|--|--|----------|
| Afinitor® | <input type="checkbox"/> 2.5 mg tablet <input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 7.5 tablet <input type="checkbox"/> 10mg tablet | <input type="checkbox"/> Take once daily <input type="checkbox"/> Other | <input type="checkbox"/> 4-week supply | |
| Afinitor Disperz® | <input type="checkbox"/> 2mg oral solution <input type="checkbox"/> 2mg oral solution <input type="checkbox"/> 5mg oral solution | <input type="checkbox"/> Take once daily <input type="checkbox"/> Other | <input type="checkbox"/> 4-week supply | |
| tadalafil | <input type="checkbox"/> 2.5mg <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg | | | |
| sildenafil | <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg | | | |
| Other | | | | |

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

Physician Signature: _____

Date: _____

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