NOBLE HEALTH SERVICES

ONCOLOGY - ORAL/TOPICAL

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: _____ Fax Number: _____
Last Four of Social: _____ Date of Birth: _____	DEA/NPI #: _____

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

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Afinitor® everolimus	Tablet: ☐ 2.5mg ☐ 5mg ☐ 7.5mg ☐ 10mg Dizperz: ☐ 2mg tablet for suspension ☐ 3mg tablet for suspension ☐ 5mg tablet for suspension		☐ 28-day supply	
Arimidex	☐ 1mg tablet	☐ Take 1 tablet by mouth once daily	☐ 30-day supply	
Aromasin	☐ 25mg tablet	☐ Take 1 tablet by mouth once daily	☐ 30-day supply	
capecitabine	☐ 150mg tablet ☐ 500mg tablet		☐ 30-day supply	
Casodex	☐ 50mg tablet	☐ Take 1 tablet by mouth once daily		
cyclophosphamide	Tablet: ☐ 25mg ☐ 50mg Capsule: ☐ 25mg ☐ 50mg			
Erivedge	☐ 150mg capsule	☐ Take 1 capsule by mouth once daily	☐ 30-day supply	
erlotinib	☐ 25mg tablet ☐ 100mg tablet ☐ 150mg tablet	☐ Take 1 tablet by mouth once daily; 1 hour before or 2 hours after injestion of food	☐ 30-day supply	
etoposide	☐ 50mg capsule			
Exjade	☐ 125mg tablet for oral suspension ☐ 250mg tablet for oral suspension ☐ 500mg tablet for oral suspension		☐ 30-day supply	
Farydak	☐ 10mg capsule ☐ 15mg capsule ☐ 20mg capsule			
Femara	☐ 2.5mg tablet	☐ Take 1 tablet by mouth once daily		

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

Physician Signature: _____ Date: _____

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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: _____ Fax Number: _____
Last Four of Social: _____ Date of Birth: _____	DEA/NPI #: _____

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Allergies: _____

Other Notes: _____

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Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Fluorouracil	☐ 5% cream ☐ 5% solution	☐ Apply as directed to cover lesions twice daily		
Gleevec imatinib mesylate	☐ 100mg tablet ☐ 400mg tablet	☐ Take _____ tablets by mouth _____ times(s) daily ☐ Other	☐ 30-day supply	
Hycamtin®	☐ 0.25 mg capsule ☐ 1 mg capsule	☐ Take _____mg by mouth on days 1, 2, 3, 4, and 5, every 21 days		
Jadenu®	Tablets: ☐ 90mg ☐ 180mg ☐ 360mg Granules: ☐ 90mg ☐ 180mg ☐ 360mg		☐ 30-day supply	
Kisqali®	☐ 200mg tablet	☐ **600mg daily dose:** Take 600mg by mouth once daily for 21 days followed by 7 days off ☐ **400mg daily dose:** Take 400mg by mouth once daily for 21 days followed by 7 days off ☐ **200mg daily dose:** Take 200mg by mouth once daily for 21 days followed by 7 days off	☐ 28-day supply	
Kisqali® + Femara®	☐ 200mg/2.5mg co-pack tablet	☐ **600mg Kisqali daily dose:** Take 600mg by mouth once daily for 21 days followed by 7 days off. Take in combination with letrozole 2.5mg by mouth once daily on days 1 to 28. ☐ **400mg Kisqali daily dose:** Take 400mg by mouth once daily for 21 days followed by 7 days off. Take in combination with letrozole 2.5mg by mouth once daily on days 1 to 28. ☐ **200mg Kisqali daily dose:** Take 200mg by mouth once daily for 21 days followed by 7 days off. Take in combination with letrozole 2.5mg by mouth once daily on days 1 to 28.	☐ 28-day supply	

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

Physician Signature: _____ Date: _____

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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: _____ Fax Number: _____
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Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Mekinist	☐ 0.5mg tablet ☐ 2mg tablet	☐ Take _____ mg by mouth once daily	☐ 30-day supply	
MuGard		☐ Rinse/coat mouth with 5-10ml for 1 minute or longer 4-6 times daily. Excess solution may be expelled or swallowed.	☐ 8oz	
Nexavar®	☐ 200mg tablet	☐ Take two tablets twice a day	☐ 30-day supply	
Nilandron	☐ 150mg tablet	☐ Take 2 tablets (300mg) by mouth once daily. ☐ Take 1 tablet (150mg) by mouth once daily.	☐ 30-day supply	
Ninlaro	☐ 2.3mg capsule ☐ 3mg capsule ☐ 4mg capsule	☐ Take 1 capsule by mouth once daily on days 1, 8, and 15 of 28 day cycle ☐ Other		
Odomzo	☐ 200mg capsule	☐ Take 1 capsule by mouth once daily on an empty stomach at least 1 hour before or 2 hours after a meal	☐ 30-day supply	
Promacta	☐ 12.5mg tablet ☐ 25mg tablet ☐ 50mg tablet ☐ 75mg tablet ☐ 12.5mg powder for oral suspension			
Purixan	☐ 20mg/ml suspension			
Rydapt	☐ 25mg capsule	☐ Take _____mg by mouth twice daily ☐ Other		
Sprycel dasatinib	☐ 20mg tablet ☐ 50mg tablet ☐ 70mg tablet ☐ 80mg tablet ☐ 100mg tablet ☐ 140mg tablet	☐ Take _____mg by mouth once daily	☐ 30-day supply	
Stivarga	☐ 40mg tablet	☐ Take 5 tablets (160mg) once daily on days 1 through 21 on 28 day cycle	☐ 30-day supply	

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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: _____ Fax Number: _____
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Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Tabloid	☐ 40mg tablet			
Tafinlar	☐ 50mg capsule ☐ 75mg capsule	☐ Take _____ mg by mouth twice daily 1 hour before or 2 hours after a meal		
tamoxifen	☐ 10mg tablet ☐ 20mg tablet ☐ 20mg/10ml solution	☐ Take _____ mg by mouth once daily	☐ 30-day supply	
Tarceva	☐ 25mg tablet ☐ 100mg tablet ☐ 150mg tablet	☐ Take one tablet by mouth once daily ☐ Other	☐ 30-day supply	
Targretin	☐ 75mg capsule ☐ 1% topical gel	☐ Take _____mg by mouth once daily with food ☐ Apply to affected areas once every other day for first week, then increase frequency of application in weekly intervals to once daily, twice daily, 3 times daily and then 4 times daily as tolerated. ☐ Other		
Tasigna nilotinib	☐ 150mg (28 capsules) ☐ 200mg (28 capsules)	☐ Take _____ capsule(s) by mouth twice daily on an empty stomach ☐ Other	☐ 30-day supply	
Temodar temozolomide	☐ 5mg ☐ 20mg ☐ 100mg ☐ 140mg ☐ 180mg ☐ 250mg	☐ Take_____ mg once daily for ___ days on and ____ days off ☐ Other	☐ 30-day supply	
Tykerb	☐ 250mg tablet	☐ Take _____ mg by mouth once daily	☐ 30-day supply	
Votrient	☐ 200mg tablet	☐ Take 4 tablets (800mg) by mouth once daily at least 1 hour before or 2 hours after a meal ☐ Other	☐ 30-day supply	

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Physician Signature: _____ Date: _____

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Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Xeloda capecitabine	☐ 150mg tablet ☐ 500mg tablet		☐ 30-day supply	
Zelboraf®	☐ 240mg tablet	☐ Take 4 tablets (960mg) by mouth every 12 hours		
Zolinza	☐ 100mg capsules	☐ Take 4 capsules (400mg) once daily with food	☐ 30-day supply	
Zytiga	☐ 250mg tablet ☐ 500mg tablet	☐ Take _____ tablets by mouth once daily at least 1 hour before or 2 hours after a meal	☐ 30-day supply	
Other				

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Physician Signature: _____ Date: _____

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