



# DERMATOLOGY

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: _____ <input type="checkbox"/> Male	Prescriber's Name: _____
Street Address: _____ <input type="checkbox"/> 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: _____	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
ICD-10 Code: _____	
Height: _____ ft _____ ins Weight: _____ lbs	Medications Failed: _____
Allergies: _____	Medications On: _____
Other Notes: _____	

PRESCRIPTION INFORMATION				
Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Actemra®	<input type="checkbox"/> 162mg/0.9ml prefilled syringe <input type="checkbox"/> 162mg/0.9ml ACTPen autoinjector	<input type="checkbox"/> Inject _____ SC every other week <input type="checkbox"/> Inject _____ SC every week <input type="checkbox"/> Other	<input type="checkbox"/> 4-week supply	
Adbry™	<input type="checkbox"/> 150mg/ml prefilled syringe	<u>Initial Loading Dose:</u> <input type="checkbox"/> Inject 600mg (4 – 150mg injections) SC on day 1 <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 300mg (2 – 150mg) SC every 2 weeks <u>Maintenance Dose option for patients weighing &lt;100kg, stable on Adbry &gt;16 weeks with clear or almost clear skin:</u> <input type="checkbox"/> Inject 300mg (2 – 150mg) SC every 4 weeks	<input type="checkbox"/> 4-week supply	
Botox	<input type="checkbox"/> 100U Vial <input type="checkbox"/> 200U Vial	<input type="checkbox"/> Inject _____ units every _____ weeks		
Cibinqo®	<input type="checkbox"/> 50mg tablet <input type="checkbox"/> 100mg tablet <input type="checkbox"/> 200mg tablet	<input type="checkbox"/> 1 tablet by mouth once daily	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply	
Cimzia®	<input type="checkbox"/> 200mg/ml prefilled syringe <input type="checkbox"/> Starter Kit	<u>Loading Dose:</u> <input type="checkbox"/> Inject 400mg SC at weeks 0, 2, and 4 <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 200mg SC every other week (option for patients <90kg body weight) <input type="checkbox"/> Inject 400mg SC every other week <input type="checkbox"/> Other	<input type="checkbox"/> 4-week supply	
Cosentyx® <i>Covered until you're covered.</i> <i>Enhanced Specialty Pharmacy Program Participant</i>	<input type="checkbox"/> 150mg pen <input type="checkbox"/> 150mg syringe	<u>Loading Dose:</u> <input type="checkbox"/> Inject 150mg at weeks 0, 1, 2, 3, 4 <input type="checkbox"/> Inject 300mg at weeks 0, 1, 2, 3, 4 <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 150mg every 4 weeks <input type="checkbox"/> Inject 300mg every 4 weeks	<input type="checkbox"/> 5-week supply (loading) <input type="checkbox"/> 4-week supply (maintenance)	
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration		

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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PATIENT INFORMATION		PROVIDER INFORMATION	
Patient Name: _____	<input type="checkbox"/> Male	Prescriber's Name: _____	
Street Address: _____	<input type="checkbox"/> 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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CLINICAL INFORMATION	
Diagnosis: _____	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
ICD-10 Code: _____	
Height: _____ ft _____ ins Weight: _____ lbs	Medications Failed: _____
Allergies: _____	Medications On: _____
Other Notes: _____	

PRESCRIPTION INFORMATION				
Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Duobrii*	<input type="checkbox"/> 0.01%/0.045% lotion	<input type="checkbox"/> Apply a thin layer of lotion topically to the affected area(s) once daily	<input type="checkbox"/> 100 gram tube	
Dupixent*	<input type="checkbox"/> 200mg/1.14ml single-dose prefilled syringe <input type="checkbox"/> 200mg/1.14ml single-dose prefilled pen <input type="checkbox"/> 300mg/2ml single-dose prefilled syringe <input type="checkbox"/> 300mg/2ml single-dose prefilled pen  <i>Prefilled pens are approved for use in patients 2 years of age and older.</i>	<b>Adult (and Pediatric Patients &gt;60 Kg)</b> <u>Initial Loading Dose:</u> <input type="checkbox"/> Inject 600mg (2 - 300mg injections) SC on day 1  <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 300mg SC every 2 weeks  <b>Pediatric Patients 6 months to 5 years of age</b> <u>Body Weight 5kg to &lt;15kg Loading &amp; Maintenance Dose</u> <input type="checkbox"/> Inject 200mg SC every 4 weeks  <u>Body Weight 15kg to &lt;30kg Loading &amp; Maintenance Dose</u> <input type="checkbox"/> Inject 300mg SC every 4 weeks  <b>Pediatric Patients 6 years to 17 years of age</b> <u>Body Weight 15kg to &lt;30kg Loading Dose:</u> <input type="checkbox"/> Inject 600mg (2 - 300mg injections) SC on day 1  <u>Body Weight 15kg to &lt;30kg Maintenance Dose:</u> <input type="checkbox"/> Inject 200mg SC every 4 weeks <input type="checkbox"/> Inject 300mg SC every 4 weeks  <u>Body Weight 30kg to &lt;60kg Loading Dose:</u> <input type="checkbox"/> Inject 400mg (2 - 200mg injections) SC on day 1  <u>Body Weight 30kg to &lt;60kg Maintenance Dose:</u> <input type="checkbox"/> Inject 200mg SC every 2 weeks  <u>Body Weight 60kg or more Loading Dose:</u> <input type="checkbox"/> Inject 600mg (2 - 300mg injections) SC on day 1  <u>Body Weight 60kg or more Maintenance Dose:</u> <input type="checkbox"/> Inject 300mg SC every 2 weeks	<input type="checkbox"/> 4-week supply	
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration		

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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PATIENT INFORMATION		PROVIDER INFORMATION	
Patient Name: _____	<input type="checkbox"/> Male	Prescriber's Name: _____	
Street Address: _____	<input type="checkbox"/> 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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### 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:
Enbrel® Enbrel® Mini Available	Standard: <input type="checkbox"/> 25mg/0.5ml prefilled syringe <input type="checkbox"/> 50mg/ml single-use prefilled syringe <input type="checkbox"/> 50mg/ml SureClick Autoinjector <input type="checkbox"/> 25mg vial  Mini: <input type="checkbox"/> 50mg Enbrel® Mini single-dose prefilled cartridge	<input type="checkbox"/> Inject 50mg SC twice a week (72-96 hours apart) <input type="checkbox"/> Inject 50mg SC once a week <input type="checkbox"/> Inject 25mg SC twice a week (72-96 hours apart) <input type="checkbox"/> Other	<input type="checkbox"/> 4-week supply	
Humira® HS Starter Kit Citrate-Free	<input type="checkbox"/> 80mg/0.8ml pen x3	Loading Dose: <input type="checkbox"/> Inject 160mg day 1, 80mg day 15, maintenance beginning on day 29 <input type="checkbox"/> Inject 80mg day 1, 80mg day 2, 80mg day 15, maintenance beginning on day 29	<input type="checkbox"/> 4-week supply	
Humira® Psoriasis/Uveitis Starter Kit Citrate-Free	<input type="checkbox"/> 80mg/0.8ml Pen x1, <input type="checkbox"/> 40mg/0.4ml Pen x2	Loading Dose: <input type="checkbox"/> Inject 80mg SC day 1, 40mg day 8, 40mg maintenance beginning on day 22	<input type="checkbox"/> 4-week supply	
Humira® Citrate-Free	<input type="checkbox"/> 40mg/0.4ml pen <input type="checkbox"/> 40mg/0.4ml prefilled syringe	<input type="checkbox"/> Inject 40mg SC every OTHER week <input type="checkbox"/> Inject 40mg SC ONCE a week	<input type="checkbox"/> 4-week supply	
Ilumya™	<input type="checkbox"/> 100mg/ml single-dose prefilled syringe	<input type="checkbox"/> Inject 100 mg SC at weeks 0,4, and every 12 weeks thereafter	<input type="checkbox"/> 4-week supply	
Inflectra®	<input type="checkbox"/> 100mg vial	Loading Dose: <input type="checkbox"/> Infuse _____ mg (5mg/kg) at 0,2 and 6 weeks then every 8 weeks thereafter via IV  Maintenance Dose: <input type="checkbox"/> Infuse _____ mg (5mg/kg) every 8 weeks via IV	<input type="checkbox"/> _____ vials	
Olumiant®	<input type="checkbox"/> 2mg tab <input type="checkbox"/> 4mg tab	<input type="checkbox"/> 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: _____	<input type="checkbox"/> Male	Prescriber's Name: _____	
Street Address: _____	<input type="checkbox"/> 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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CLINICAL INFORMATION	
Diagnosis: _____	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
ICD-10 Code: _____	
Height: _____ ft _____ ins Weight: _____ lbs	Medications Failed: _____
Allergies: _____	Medications On: _____
Other Notes: _____	

PRESCRIPTION INFORMATION				
Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Opzelura™	<input type="checkbox"/> 1.5% topical cream	<input type="checkbox"/> Apply a thin layer topically twice daily to affected areas of up to 20% of body surface area.  <i>Do not use more than one 60 gram tube per week or one 100 gram tube every 2 weeks.</i>	<input type="checkbox"/> 60 gram tube <input type="checkbox"/> 100 gram tube	
Otezla®	<input type="checkbox"/> 28-day starter pack titration <input type="checkbox"/> 30 mg tablet	<input type="checkbox"/> Initial Dose titration per starter pack <input type="checkbox"/> Take 30mg by mouth twice daily	<input type="checkbox"/> Starter Kit <input type="checkbox"/> Bottle of 60	
Otrexup	<u>Autoinjector:</u> <input type="checkbox"/> 10mg/0.4ml <input type="checkbox"/> 20mg/0.4ml <input type="checkbox"/> 12.5mg/0.4ml <input type="checkbox"/> 22.5mg/0.4ml <input type="checkbox"/> 15mg/0.4ml <input type="checkbox"/> 25mg/0.4ml <input type="checkbox"/> 17.5mg/0.4ml	<input type="checkbox"/> Inject _____ mg SC once weekly <input type="checkbox"/> Other	<input type="checkbox"/> 4-week supply	
Rasuvo®	<u>Autoinjector:</u> <input type="checkbox"/> 7.5mg/0.15ml <input type="checkbox"/> 20mg/0.4ml <input type="checkbox"/> 10mg/0.2ml <input type="checkbox"/> 22.5mg/0.45ml <input type="checkbox"/> 12.5mg/0.25ml <input type="checkbox"/> 25mg/0.5ml <input type="checkbox"/> 15mg/.3ml <input type="checkbox"/> 27.5mg/0.55ml <input type="checkbox"/> 17.5mg/0.35ml <input type="checkbox"/> 30mg/0.6ml	<input type="checkbox"/> Inject _____ mg SC once weekly <input type="checkbox"/> Other	<input type="checkbox"/> 4-week supply	
Rayos®	<input type="checkbox"/> 1mg tablet <input type="checkbox"/> 2mg tablet <input type="checkbox"/> 5mg tablet	<input type="checkbox"/> Take _____ mg by mouth once per day <input type="checkbox"/> Other	<input type="checkbox"/> _____ -day supply	
Remicade®	<input type="checkbox"/> 100mg vial	<u>Loading Dose:</u> <input type="checkbox"/> Infuse _____ mg (5mg/kg) at 0, 2 and 6 weeks, then every 8 weeks thereafter via IV  <u>Maintenance Dose:</u> <input type="checkbox"/> Infuse _____ mg (5mg/kg) every 8 weeks via IV <input type="checkbox"/> Infuse _____ mg (5mg/kg) every _____ weeks via IV  <input type="checkbox"/> Other	<input type="checkbox"/> _____ vials	
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration		

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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PATIENT INFORMATION	PROVIDER INFORMATION
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Street Address: _____ <input type="checkbox"/> 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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ICD-10 Code: _____	
Height: _____ ft _____ ins Weight: _____ lbs	Medications Failed: _____
Allergies: _____	Medications On: _____
Other Notes: _____	

PRESCRIPTION INFORMATION				
Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Renflexis®	<input type="checkbox"/> 100mg vial	<u>Loading Dose:</u> <input type="checkbox"/> Infuse _____ mg (5mg/kg) at 0, 2 and 6 weeks, then every 8 weeks thereafter via IV  <u>Maintenance Dose:</u> <input type="checkbox"/> Infuse _____ mg (5mg/kg) every 8 weeks via IV	<input type="checkbox"/> _____ vials	
Rinvoq™ <i>AbbVie has contracted with Noble Health Services to provide product specific support.</i>	<input type="checkbox"/> 15mg tablet <input type="checkbox"/> 30mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily	<input type="checkbox"/> 30-day supply	
Siliq™	<input type="checkbox"/> 210mg/1.5ml prefilled syringe	<input type="checkbox"/> Inject 210mg SC at weeks 0,1, and 2 and 210mg SC every 2 weeks thereafter	<input type="checkbox"/> Starter Dose (3 syringes) <input type="checkbox"/> Maintenance Dose (2 syringes)	
Simponi®	<input type="checkbox"/> 100mg/1ml SmartJect Autoinjector <input type="checkbox"/> 100mg/1ml Prefilled Syringe <input type="checkbox"/> 50mg/0.5ml SmartJect Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 100mg SC once a month <input type="checkbox"/> Inject 50mg SC once a month	<input type="checkbox"/> 4-week supply	
Skyrizi™ <i>AbbVie has contracted with Noble Health Services to provide product specific support.</i>	<input type="checkbox"/> 150mg/mL prefilled syringe <input type="checkbox"/> 150mg/mL pen	<u>Loading Dose:</u> <input type="checkbox"/> Inject 150mg SC at weeks 0, 4, and every 12 weeks thereafter  <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 150mg SC every 12 weeks	<input type="checkbox"/> 1 prefilled syringe/pen	

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: _____ <input type="checkbox"/> Male	Prescriber's Name: _____
Street Address: _____ <input type="checkbox"/> 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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CLINICAL INFORMATION	
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ICD-10 Code: _____	
Height: _____ ft _____ ins Weight: _____ lbs	Medications Failed: _____
Allergies: _____	Medications On: _____
Other Notes: _____	

PRESCRIPTION INFORMATION				
Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Sotykyu™	<input type="checkbox"/> 6mg tablet	<input type="checkbox"/> Take 1 tablet (6mg) by mouth once daily	<input type="checkbox"/> 30-day supply	
Stelara®	<input type="checkbox"/> 45mg/0.5ml prefilled syringe <input type="checkbox"/> 90mg/ml prefilled syringe	<u>Patients weighing &lt;100kg:</u> <input type="checkbox"/> Inject 45mg SC at 0 and 4 weeks, then every 12 weeks thereafter  <u>Patients weighing &gt;100kg:</u> <input type="checkbox"/> Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter	<input type="checkbox"/> 2 syringes (loading) <input type="checkbox"/> 1 syringe (maintenance)	
Taltz®	<input type="checkbox"/> 80mg/ml single-dose prefilled autoinjector <input type="checkbox"/> 80mg/ml single-dose prefilled syringe	<u>Loading Dose:</u> <input type="checkbox"/> Inject 160mg SC at week 0 followed by 80mg SC on weeks 2,4,6,8,10, and 12  <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 80mg SC every 4 weeks	<input type="checkbox"/> 3 syringes/pens <input type="checkbox"/> 2 syringes/pens <input type="checkbox"/> 1 syringe/pen	
Tremfya®	<input type="checkbox"/> 100mg/ml prefilled syringe <input type="checkbox"/> 100mg/ml prefilled autoinjector	<u>Loading Dose:</u> <input type="checkbox"/> Inject 100mg SC at weeks 0, 4, and every 8 weeks thereafter  <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 100mg SC every 8 weeks	<input type="checkbox"/> 4 week supply (loading) <input type="checkbox"/> 8 week supply (maintenance)	
Vtama®	1% topical cream	<input type="checkbox"/> Apply a thin layer to affected areas once daily	<input type="checkbox"/> 60 gram tube	
Other				

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

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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