NOBLE HEALTH SERVICES

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: _____ ☐ 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:
Actemra®	☐ 162mg/0.9ml prefilled syringe ☐ 162mg/0.9ml ACTPen autoinjector	☐ Inject _____ SC every other week ☐ Inject _____ SC every week ☐ Other	☐ 4-week supply	
Botox	☐ 100U Vial ☐ 200U Vial	☐ Inject _____ units every _____ weeks		
Cimzia®	☐ 200mg/ml prefilled syringe ☐ Starter Kit	Loading Dose: ☐ Inject 400mg SC at weeks 0, 2, and 4 Maintenance Dose: ☐ Inject 200mg SC every other week ☐ Inject 400mg SC every 4 weeks ☐ Other	☐ 4-week supply	
Cosentyx ® *Enhanced Specialty Pharmacy Program Participant	☐ 150mg pen ☐ 150mg syringe	Loading Dose: ☐ Inject 150mg at weeks 0, 1, 2, 3, 4 ☐ Inject 300mg at weeks 0, 1, 2, 3, 4 Maintenance Dose: ☐ Inject 150mg every 4 weeks ☐ Inject 300mg every 4 weeks	☐ 5-week supply (loading) ☐ 4-week supply (maintenance)	
Cosentyx ® *Enhanced Specialty Pharmacy Program Participant ***Covered Until You're Covered***	☐ 150mg pen ☐ 150mg syringe	Loading Dose: ☐ Inject 150mg at weeks 0, 1, 2, 3, 4 ☐ Inject 300mg at weeks 0, 1, 2, 3, 4 Maintenance Dose: ☐ Inject 150mg every 4 weeks ☐ Inject 300mg every 4 weeks	☐ 5-week supply (loading) ☐ 4-week supply (maintenance)	

☐ 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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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:
Duobrii®	☐ 0.01%/0.045% lotion	☐ Apply a thin layer of lotion topically to the affected area(s) once daily	☐ 100 gram tube	
Dupixent®	☐ 300mg/ 2ml prefilled syringe ☐ 300mg/2mL prefilled PEN ☐ 200mg/1.14ml prefilled syringe	**Adult (and Pediatric Patients >60 Kg)** Loading Dose: ☐ Inject 600mg (Two-300mg injections) SC on day 1 Maintenance Dose: ☐ Inject 300mg every 2 weeks **Pediatric Patients 30kg to <60kg** Loading Dose ☐ Inject 400mg (Two- 200mg injections) SC on day 1 Maintenance Dose: ☐ Inject 200mg every 2 weeks **Pediatric Patients 15kg to <30 kg** Loading Dose: ☐ Inject 600mg (two-300mg injections) SC on day 1 Maintenance Dose: ☐ Inject 300mg every 4 weeks	☐ 4-week supply	
Enbrel® **Enbrel® Mini Available**	Standard: ☐ 25mg/0.5ml prefilled syringe ☐ 50mg/ml single-use prefilled syringe ☐ 50mg/ml SureClick Autoinjector ☐ 25mg vial Mini: ☐ 50mg Enbrel® Mini single-dose prefilled cartridge	☐ Inject 50mg SC twice a week (72-96 hours apart) ☐ Inject 50mg SC once a week ☐ Inject 25mg SC twice a week (72-96 hours apart) ☐ Other	☐ 4-week supply	

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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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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:
Humira® HS Starter Kit **Citrate-Free**	☐ 80mg/0.8ml pen x3	Loading Dose: ☐ Inject 160mg day 1, 80mg day 15, maintenance beginning on day 29 ☐ Inject 80mg day 1, 80mg day 2, 80mg day 15, maintenance beginning on day 29	☐ 4-week supply	
Humira® Psoriasis/ Uveitis Starter Kit **Citrate-Free**	☐ 80mg/0.8ml Pen x1, ☐ 40mg/0.4ml Pen x2	Loading Dose: ☐ Inject 80mg SC day 1, 40mg day 8, 40mg maintenance beginning on day 22	☐ 4-week supply	
Humira® **Citrate-Free**	☐ 40mg/0.4ml pen ☐ 40mg/0.4ml prefilled syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	☐ 4-week supply	
Ilumya™	☐ 100mg/ml single-dose prefilled syringe	☐ Inject 100 mg SC at weeks 0,4, and every 12 weeks thereafter	☐ 4-week supply	
Inflectra®	☐ 100mg vial	Loading Dose: ☐ Infuse ____mg (5mg/kg) at 0,2 and 6 weeks then every 8 weeks thereafter via IV Maintenance Dose: ☐ Infuse ____ mg (5mg/kg) every 8 weeks via IV	☐ _____ vials	
Otezla®	☐ 28-day starter pack titration ☐ 30 mg tablet	☐ Initial Dose titration per starter pack ☐ Take 30mg by mouth twice daily	☐ Starter Kit ☐ Bottle of 60	
Otrexup	Autoinjector: ☐ 10mg/0.4ml ☐ 20mg/0.4ml ☐ 12.5mg/0.4ml ☐ 22.5mg/0.4ml ☐ 15mg/0.4ml ☐ 25mg/0.4ml ☐ 17.5mg/0.4ml	☐ Inject _____ mg SC once weekly ☐ Other	☐ 4-week supply	

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

Physician Signature: _____ Date: _____

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

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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:
Rasuvo®	Autoinjector: ☐ 7.5mg/0.15ml ☐ 10mg/0.2ml ☐ 12.5mg/0.25ml ☐ 15mg/.3ml ☐ 17.5mg/0.35ml ☐ 20mg/0.4ml ☐ 22.5mg/0.45ml ☐ 25mg/0.5ml ☐ 27.5mg/0.55ml ☐ 30mg/0.6ml	☐ Inject _____mg SC once weekly ☐ Other	☐ 4-week supply	
Rayos®	☐ 1mg tablet ☐ 2mg tablet ☐ 5mg tablet	☐ Take _____mg by mouth once per day ☐ Other	☐ _____ - day supply	
Remicade®	☐ 100mg vial	Loading Dose: ☐ Infuse _____ mg (5mg/kg) at 0, 2 and 6 weeks, then every 8 weeks thereafter via IV Maintenance Dose: ☐ Infuse _____mg (5mg/kg) every 8 weeks via IV ☐ Infuse _____mg (5mg/kg) every_____ weeks via IV ☐ Other	☐ _____ vials	
Renflexis®	☐ 100mg vial	Loading Dose: ☐ Infuse _____ mg (5mg/kg) at 0, 2 and 6 weeks, then every 8 weeks thereafter via IV Maintenance Dose: ☐ Infuse _____mg (5mg/kg) every 8 weeks via IV	☐ _____ vials	
Siliq™	☐ 210mg/1.5ml prefilled syringe	☐ Inject 210mg SC at weeks 0,1, and 2 and 210mg SC every 2 weeks thereafter	☐ Starter Dose (3 syringes) ☐ Maintenance Dose (2 syringes)	

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

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Diagnosis: _____

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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:
Simponi®	☐ 100mg/1ml SmartJect Autoinjector ☐ 100mg/1ml Prefilled Syringe ☐ 50mg/0.5ml SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 100mg SC once a month ☐ Inject 50mg SC once a month	☐ 4-week supply	
Skyrizi™	☐ 75mg/0.83mL prefilled syringe	Loading Dose: ☐ Inject 150mg (2-75mg syringes) SC at weeks 0, 4, and every 12 weeks theraftер Maintenance Dose: ☐ Inject 150mg SC every 12 weeks	☐ 2 prefilled syringes	
Stelara®	☐ 45mg/0.5ml prefilled syringe ☐ 90mg/ml prefilled syringe	Patients weighing <100kg: ☐ Inject 45mg SC at 0 and 4 weeks, then every 12 weeks thereafter Patients weighing >100kg: ☐ Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter	☐ 2 syringes (loading) ☐ 1 syringe (maintenance)	
Taltz®	☐ 80mg/ml single-dose prefilled autoinjector ☐ 80mg/ml single-dose prefilled syringe	Loading Dose: ☐ Inject 160mg SC at week 0 followed by 80mg SC on weeks 2,4,6,8,10, and 12 Maintenance Dose: ☐ Inject 80mg SC every 4 weeks	☐ 3 syringes/ pens ☐ 2 syringes/ pens ☐ 1 syringe/pen	
Tremfya®	☐ 100mg/ml prefilled syringe ☐ 100mg/ml prefilled autoinjector	☐ Inject ____ mg at weeks 0, 4, then every 8 weeks thereafter	☐ 4 week supply (loading) ☐ 8 week supply (maintenance)	
Other				

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Physician Signature: _____ Date: _____

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