NOBLE HEALTH SERVICES

HEPATITIS C
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: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Viral Load: _____ Genotype: _____

Metavir Fibrosis Score: _____

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Cirrhosis: ☐ Yes ☐ No

If yes, decompensated? ☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Daklinza	☐ 30mg tablet ☐ 60mg tablet ☐ 90mg tablet	☐ Take one tablet by mouth once daily	☐ 4-week supply	
Epclusa®	☐ 400-100mg tablets	☐ Take one tablet by mouth once daily	☐ 4-week supply	
Harvoni®	☐ 90-400mg tablets	☐ Take one tablet by mouth once daily	☐ 4-week supply	
Mavyret®	☐ 100/40mg	☐ Take 3 tablets by mouth one time daily with food	☐ 4-week supply	
Pegasys®	☐ 180mcg/ml Single-Dose Vial ☐ 180mcg/0.5ml prefilled syringe ☐ 180mcg/0.5ml autoinjector	☐ Inject 180mcg SC once weekly		
Ribavirin®	☐ 200mg tablet ☐ 200mg capsules	☐ Take _____ tablet(s) by mouth _____ time(s) daily ☐ Take _____ capsule(s) by mouth _____ time(s) daily	☐ 4-week supply	
Solvaldi®	☐ 400 mg tablet	☐ Take one tablet by mouth once daily	☐ 4-week supply	
Vosevi®	☐ 400/100/100mg tablet	☐ Take 1 tablet by mouth once a day with food	☐ 4-week supply	
Zepatier®	☐ 50/100mg tablet	☐ One tablet by mouth once a day with food	☐ 4-week supply	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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

www.noblehealthservices.com