



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	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: _____
Last Four of Social: _____ Date of Birth: _____	Fax Number: _____
Translator Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____	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	Cirrhosis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Viral Load: _____ Genotype: _____	If yes, decompensated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Metavir Fibrosis Score: _____	Medications Failed: _____
Allergies: _____	Medications On: _____
Other Notes: _____	

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

Important Notice: This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy. V.Q420201