Dermatology Enrollment Form
Medications A-L

www.noblehealthservices.com

NOBLE HEALTH SERVICES
A SPECIALTY PHARMACY

Signature Care Program

☐ **Noble Syracuse**
Phone: (888) 843-2040
Fax: (888) 842-3977
☐ **Noble Mississippi**
Phone: (866) 420-4041
Fax: (601) 420-4040

Delivery Need By: Delivery to: ☐Patients Home ☐Physician's Office ☐Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐Female ☐Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ☐ Atopic Dermatitis L20 ☐ Psoriasis L40 ☐ Psoriatic arthritis L40.5 ☐Hidradenitis Suppurativa L73.2 ☐ Other	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Last PPD Test M/D/Y ☐ Positive ☐ Negative Date: / /	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Actemra®	☐ 162mg/0.9ml	☐ SC every OTHER week ☐ SC every week ☐ Other:	☐ 4 week supply ☐ Other:	
Botox®	☐ 100U VIAL ☐ 200U VIAL	☐ Inject Units every _____ weeks	☐ Vials	
Cimzia®	☐ 200mg/ml Prefilled SYR ☐ Starter Kit	Loading Dose: ☐ Inject 400mg SC at weeks 0,2 and 4 Maintenance Dose: ☐ 200mg SC every other week ☐ 400mg SC every 4 weeks	☐ 4 week supply	
Cosentyx ™ **Enhanced Specialty Pharmacy Program Participant*	☐ 150mg Pen ☐ 150mg SYR	Loading Dose: ☐ 150mg 0,1,2,3,4 weeks ☐ 300mg 0,1,2,3,4 weeks Maintenance Dose: ☐ 150mg every 4 weeks ☐ 300mg every 4 weeks	☐ 4 week supply (maintenance) ☐ 5 week supply (loading) ☐ Other:	
Cosentyx ™ **Enhanced Specialty Pharmacy Program Participant* ***Covered Until You're Covered***	☐ 150mg Pen ☐ 150mg Syringe	Loading Dose: ☐ 150mg 0,1,2,3,4 weeks ☐ 300mg 0,1,2,3,4 weeks Maintenance Dose: ☐ 150mg every 4 weeks ☐ 300mg every 4 weeks	☐ 4 week supply (maintenance) ☐ 5 week supply (loading) ☐ Other:	
Dupixent®	☐ 300mg/ml Prefilled SYR	Loading Dose: ☐ Inject two 300mg SC once Maintenance Dose: ☐ Inject 300mg every other week	☐ 4 week supply (maintenance) ☐ 5 week supply (loading) ☐ Other:	
Enbrel®	☐ 50mg/ml Single Use Prefilled SYR ☐ 50mg/ml SureClick Autoinjector ☐ 25mg/0.5ml Prefilled SYR ☐ 25mg Vial	☐ 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 ☐ Other:	
Humira HS Starter Kit	☐ 40mg/0.8ml Pen x6 (Starter Kit) ☐ 80mg/0.8ml Pen x3 **(Citrate-Free)**	Loading Dose: ☐ Inject 160 mg day 1, 80 mg day 15, maintenance beginning on day 29 OR ☐ Inject 80 mg Day 1, 80mg Day 2, 80mg on Day 15, maintenance beginning on day 29	☐ 4 week supply ☐ Other:	
Humira® Psoriasis/Uveitis Starter Kit *Citrate-Free*	☐ 40mg/0.8ml Pen x4 (Starter Kit) ☐ 80mg/0.8ml Pen x1, 40mg/0.4ml Pen x2 **(Citrate-Free)**	Loading Dose: ☐ Inject 80 mg SC day 1, 40 mg day 8, 40 mg maintenance beginning on day 22	☐ 4 week supply ☐ Other:	
Humira®	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled SYR ☐ 40mg/0.4ml Pen **(Citrate-Free)** ☐ 40mg/0.4ml Prefilled SYR **(Citrate-Free)**	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	☐ 4 week supply ☐ Other:	
☐ Patient is interested in patient support programs			☐ Ancillary supplies provided for administration	

Office Contact Name: _____ Preferred Phone Number & Extension: _____

Physician Signature: _____ Date: _____

E-Scribe Rx and Fax this Form

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Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

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Last PPD Test M/D/Y ☐ Positive ☐ Negative Date: / /	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Inflectra®	☐ 100 mg VIAL	☐Induction Dose: 5mg/kg (Dose _____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter ☐ Maintenance Dose: 5mg/kg (Dose _____mg) IV every 8 weeks	☐ _____Vials	
Otezla®	☐ 28 day starter pack titration ☐ 30mg	☐ Initial dosage titration per starter pack ☐ 30mg twice daily taken orally	☐ 1 month starter pack ☐ Bottle of 60 ☐ Other:	
Remicade®	☐ 100 MG VIAL	☐Induction Dose: 5mg/kg (Dose _____mg) IV at 0, 2, and 6 weeks then every 8 weeks thereafter ☐Maintenance Dose: 5mg/kg (Dose _____mg) IV every 8 weeks ☐ IV mg every weeks	☐ _____Vials	
Renflexis™	☐ 100 MG VIAL	☐ Induction Dose: 5mg/kg (Dose_____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter. ☐ Maintenance Dose: 5mg/kg (Dose _____mg) IV every 8 weeks	☐ _____Vials	
Simponi®	☐ 100mg/1ml SmartJect Autoinjector ☐ 100mg/1ml Prefilled SYR ☐ 50mg/0.5ml SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled SYR	☐ Inject 100mg SC ONCE a month ☐ Inject 50mg SC ONCE a month	☐ 4 week supply ☐ Other:	
Siliq™	☐ 210mg/1.5ml Prefilled SYR	☐ Inject 210mg SC at weeks: 0, 1 and 2 and 210mg SC every 2 weeks thereafter	☐ Starter Dose (3 SYR) ☐ Maintenance Dose (2 SYR)	
Stelara®	☐ 45mg/0.5ml Prefilled SYR ☐ 90mg/ml Prefilled SYR	☐ 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 SYR loading ☐ 1 SYR maintenance	
Taltz ®	☐ 80mg/ml single-dose Prefilled Autoinjector ☐ 80mg/ml single-dose Prefilled SYR	Psoriasis 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 SYR	☐ Inject mg at weeks 0, 4, then every 8 weeks thereafter	☐ Loading Dose/ 4 week supply ☐ Maintenance/ 8 week supply	
Other:				

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

Office Contact Name: _____ Preferred Phone Number & Extension: _____

Physician Signature: _____ Date: _____

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