Psoriasis Enrollment Form
Medications A-O

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:
Last four of Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ☐ Psoriasis L40 ☐ Psoriatic arthritis L40.5 ☐ Other	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Last PPD Test ☐ Positive ☐ Negative Date:	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Cosentyx ™ **Enhanced Specialty Pharmacy Program Participant*	☐ 150mg Pen ☐ 150mg SYR	☐ Loading Dose: 300mg 0,1,2,3,4 weeks ☐ Maintenance Dose: 300mg every 4 weeks ☐ Other:	☐ 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: ☐ 300mg 0,1,2,3,4 weeks ☐ Other: Maintenance Dose: ☐ 300mg every 4 weeks	☐ 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	☐ Loading Dose: Inject 50mg SC TWICE a week (72-96 hours apart) for three months then maintenance dosing ☐ Maintenance Dose: Inject 50mg SC ONCE a week	☐ 4 week supply ☐ Other:	
Humira® Psoriasis-Starter Kit	☐ 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	☐ 4 week supply ☐ Other:	
Ilumya	☐ 100 mg/ml Prefilled syringe	☐ Loading Dose: 100 mg SC at Weeks 0 and 4, then and every 12 weeks thereafter for maintenance dosing ☐ Maintenance Dose: 100 mg SC every 12 weeks	☐ _____Vials	
Otezla®	☐ 28 day starter pack titration ☐ 30mg	☐ Induction Dose: Titration per starter pack ☐ Maintenance Dose: 30mg twice daily taken orally	☐ 1 month starter pack ☐ Bottle of 60 ☐ Other:	
Otrexup	☐ 10 mg/0.4ml Prefilled Autoinjector ☐ 17.5 mg/0.4ml Prefilled Autoinjector ☐ 12.5 mg/ 0.4ml Prefilled Autoinjector ☐ 20 mg/ 0.4 ml Prefilled Autoinjector ☐ 15 mg/ 0.4 ml Prefilled Autoinjector ☐ 22.5 mg/ 0.ml Prefilled Autoinjector ☐ 25 mg/0.4ml Prefilled Autoinjector	☐ Inject _____ mg once weekly	☐ Prefilled Autoinjector	
☐ 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:
Last four of Social Security Number:	DEA/NPI#:

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CLINICAL INFORMATION

Diagnosis: ☐ Psoriasis L40 ☐ Psoriatic arthritis L40.5 ☐ Other	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Last PPD Test ☐ Positive ☐ Negative Date:	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Rasuvo	☐ 7.5 mg /0.15ml Prefilled Autoinjector ☐ 20 mg/0.4ml Prefilled Autoinjector ☐ 10 mg/0.2ml Prefilled Autoinjector ☐ 22.5 mg/0.45ml Prefilled Autoinjector ☐ 12.5 mg /0.25ml Prefilled Autoinjector ☐ 25 mg /0.5ml Prefilled Autoinjector ☐ 15 mg /0.3ml Prefilled Autoinjector ☐ 27.5 mg/0.55ml Prefilled Autoinjector ☐ 17.5 mg/0.35ml Prefilled Autoinjector ☐ 30 mg/0.6ml Prefilled Autoinjector	☐ Inject _____ mg once weekly	☐ _____ Prefilled autoinjectors	
Rayos	☐ 1mg tablet ☐ 2 mg tablet ☐ 5 mg tablet	☐ Take __ Mg by mouth daily	☐ _____ Prefilled autoinjectors	
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	
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	☐ 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 SC 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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