E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE SYRACUSE**
Tel: 888-843-2040
Fax: **888-842-3977**

☐ **NOBLE MISSISSIPPI**
Tel: 866-420-4041
Fax: **601-420-4040**

Hepatitis B

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches Weight: _____ lbs

Allergies: _____

Viral Load: _____ Genotype: _____

Metavir Fibrosis Score: _____

Has the patient been treated previously for this condition?
☐ Yes ☐ No

Cirrhosis: ☐ Yes ☐ No
If yes, Decompensated? ☐ Yes ☐ No
Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Baraclude	☐ 0.5 MG tablet ☐ 1MG tablet ☐ 0.05MG/ML	☐ Take one 0.5MG tablet by mouth daily ☐ Take one 1 mg tablet by mouth daily ☐ Take _____ ml by mouth daily	☐ 30 day supply ☐ Other	
Epivir HBV	☐ 100mg tablet ☐ 5 mg/ml solution	☐ Take one 100 mg tablet by mouth daily ☐ Take _____ ml by mouth daily	☐ 30 Day Supply ☐ Other	
Hepsera	☐ 10mg tablet	☐ Take one 10 mg tablet by mouth daily	☐ 30 Day Supply ☐ Other	
Intron- A	☐ 10 million unit powder for injection ☐ 25 million unit solution for injection			
Tyzeka	☐ 600 mg tablet	☐ Take one 600 mg tablet by mouth daily	☐ 30 day supply ☐ Other	
Vemlidy	☐ 25 mg tablet	☐ Take one 25 mg by mouth daily with food	☐ 30 day supply ☐ Other	
Viread	☐ 300 mg tablet	☐ Take one 300 mg tablet by mouth daily ☐ Other	☐ 30 day supply ☐ Other	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____