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**

Dermatology

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

Last PPD Test: ☐ Positive ☐ Negative Date: _____

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Actemra®	☐ 162 mg/0.9 ml single-dose prefilled syringe ☐ 162 mg/0.9 ml autoinjector	☐ Inject 162 mg SC every OTHER week ☐ Inject 162 mg SC every week ☐ Other	☐ 4 week supply ☐ Other	
Botox®	☐ 100U Vial ☐ 200U Vial	☐ Inject _____ units every _____ weeks	☐ _____ vials	
Cimzia®	☐ 200 mg/ml Prefilled SYR ☐ Starter Kit	Loading Dose: ☐ Inject 400 mg SC at weeks 0, 2 and 4 Maintenance Dose: ☐ Inject 200 mg SC every other week ☐ Inject 400 mg SC every 4 weeks ☐ Other	☐ 4 week supply ☐ Other	
Cosentyx *Enhanced Specialty Pharmacy Program Participant*	☐ 150 mg Pen ☐ 150 mg SYR	Loading Dose: ☐ Inject 150 mg SC at weeks 0, 1, 2, 3, 4 ☐ Inject 400 mg SC at weeks 0, 1, 2, 3, 4 Maintenance Dose: ☐ Inject 150 mg SC every 4 weeks ☐ Inject 300 mg SC every 4 weeks	☐ 5 week supply (loading) ☐ 4 week supply (loading) ☐ Other	
Cosentyx *Enhanced Specialty Pharmacy Program Participant* ***Covered Until You're Covered***	☐ 150 mg Pen ☐ 150 mg SYR	Loading Dose: ☐ Inject 150 mg SC at weeks 0, 1, 2, 3, 4 ☐ Inject 400 mg SC at weeks 0, 1, 2, 3, 4 Maintenance Dose: ☐ Inject 150 mg SC every 4 weeks ☐ Inject 300 mg SC every 4 weeks	☐ 5 week supply (loading) ☐ 4 week supply (loading) ☐ Other	
Dupixent®	☐ 300 mg/ml Prefilled SYR	Loading Dose: ☐ Inject two 300 mg SC once Maintenance Dose: ☐ Inject 300 mg SC every 4 weeks	☐ 5 week supply (loading) ☐ 4 week supply (maintenance)	
Enbrel® ***Enbrel Mini Available***	Standard: ☐ 25mg/0.5ml Prefilled SYR ☐ 50mg/ml Single Use Prefilled SYR ☐ 50mg/ml SureClick Autoinjector ☐ 25mg Vial Mini: ☐ 50mg Enbrel Mini single dose prefilled cartridge	☐ 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	☐ 40 mg/0. 8 ml Pen x 6 (Starter Kit) ☐ 80 mg.0.8ml Pen x3 ***(Citrate-Free)***	Loading Dose: ☐ Inject 160 mg SC day 1, 80 mg day 15, maintenance beginning on day 29 ☐ Inject 80 mg SC Day 1, 80mg Day 2, 80mg on Day 15, maintenance beginning on day 29	☐ 4 week supply ☐ Other	

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

Physician Signature: _____ Date: _____

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

Patient Name: _____ DOB: _____

Prescriber's Name: _____

PRESCRIPTION INFORMATION				
Medication:	**Dosage/Strength:**	**Directions:**	**Quantity:**	**Refills:**
Humira® Psoriasis/Uveitis Starter Kit ***Citrate-Free***	☐ 40mg/0.8ml Pen x4 (Starter Kit) ☐ 80mg/0.8ml Pen x1, 40mg/0.4ml Pen x2	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	
Inflectra®	☐ 100 mg VIAL	Loading 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 tablet	☐ Initial dosage titration per starter pack ☐ Take 30mg by mouth twice daily	☐ 1 month starter pack ☐ Bottle of 60 ☐ Other	
Remicade®	☐ 100 MG VIAL	Loading 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	
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)	
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	
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 at weeks 0, 4, then every 8 weeks thereafter	☐ 4 week supply (loading) ☐ 8 week supply (maintenance)	
Other				
☐ Patient is interested in patient support programs		☐ Ancillary supplies provided for administration		

Physician Signature: _____ Date: _____