

# Rheumatology Enrollment Form Medications A-I

www.noblehealthservices.com



## Signature Care Program

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

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

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: <input type="checkbox"/> Female <input type="checkbox"/> 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/ ICD-10 Code:	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last PPD Test <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: M/D/Y	Medications failed:
Height: _____ feet _____ inches Weight: _____ lbs.	Medications on:
Allergies:	Other notes:

### PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
<b>Actemra®</b>	<input type="checkbox"/> 162mg/0.9ml Prefilled syringe  <input type="checkbox"/> 80 mg/4ml Vial <input type="checkbox"/> 200mg/10ml Vial <input type="checkbox"/> 400mg/20ml Vial	<input type="checkbox"/> SC every OTHER week <input type="checkbox"/> SC every week  <input type="checkbox"/> Induction dose: 4mg/kg ( _____ mg dose) every 4 weeks. <input type="checkbox"/> Maintenance dose: 8mg/kg ( _____ mg dose) every 4 weeks.	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Cimzia®</b>	<input type="checkbox"/> 200mg/ml Prefilled SYR <input type="checkbox"/> Starter Kit	<input type="checkbox"/> Initial Dose: Inject 400mg SC at weeks 0,2, and 4, then: Maintenance Dose: <input type="checkbox"/> 200mg SC every other week OR <input type="checkbox"/> 400mg SC every 4 weeks	<input type="checkbox"/> 4 week supply	
<b>Cosentyx™</b> <i>*Enhanced Specialty Pharmacy Program Participant</i>	<input type="checkbox"/> 150mg Pen <input type="checkbox"/> 150mg Syringe	Loading Dose: <input type="checkbox"/> 150mg 0,1,2,3,4 weeks <input type="checkbox"/> 300mg 0,1,2,3,4 weeks Maintenance Dose: <input type="checkbox"/> 150mg every 4 weeks <input type="checkbox"/> 300mg every 4 weeks	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other:	
<b>Cosentyx™</b> <i>*Enhanced Specialty Pharmacy Program Participant Covered Until You're Covered</i>	<input type="checkbox"/> 150mg Pen <input type="checkbox"/> 150mg Syringes	Loading Dose: <input type="checkbox"/> 150mg 0,1,2,3,4 weeks <input type="checkbox"/> 300mg 0,1,2,3,4 weeks Maintenance Dose: <input type="checkbox"/> 150mg every 4 weeks <input type="checkbox"/> 300mg every 4 weeks	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other:	
<b>Enbrel®</b>	<input type="checkbox"/> 50mg/ml Single Use Prefilled SYR <input type="checkbox"/> 50mg/ml SureClick AutoInjector <input type="checkbox"/> 25mg/0.5ml Prefilled SYR <input type="checkbox"/> 25mg Vial	<input type="checkbox"/> Inject 50mg SC TWICE a week (72-96 hours apart) <input type="checkbox"/> Inject 50mg SC ONCE a week <input type="checkbox"/> Inject 25mg SC TWICE a week (72-96 hours apart) <input type="checkbox"/> Other:	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Humira®</b>	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled SYR <input type="checkbox"/> 40mg/0.4ml Pen (Citrate-Free) <input type="checkbox"/> 40mg/0.4ml Prefilled SYR (Citrate-Free)	<input type="checkbox"/> Inject 40mg SC every OTHER week <input type="checkbox"/> Inject 40mg SC ONCE a week	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Inflectra®</b>	<input type="checkbox"/> 100 MG VIAL	<input type="checkbox"/> Induction Dose: 5mg/kg (Dose _____ mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: 5mg/kg (Dose _____ mg) IV every 8 weeks <input type="checkbox"/> Other:		
<input type="checkbox"/> Patient is interested in patient support programs			<input type="checkbox"/> 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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**Rheumatology Enrollment**  
**Form Medications J-Z**  
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Delivery Need By: \_\_\_\_\_ Delivery to:  Patients Home  Physician's Office  Other

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name:	<input type="checkbox"/> Female <input type="checkbox"/> 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/ ICD-10 Code:	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last PPD Test <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: M/D/Y	Medications failed:
Height: _____ feet _____ inches Weight: _____ lbs.	Medications on:
Allergies:	Other notes:

**PRESCRIPTION INFORMATION**

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
<b>Kevzara®</b>	<input type="checkbox"/> 150mg/1.14ml Prefilled SYR <input type="checkbox"/> 150mg/1.14ml Prefilled Pen <input type="checkbox"/> 200mg/1.14ml Prefilled SYR <input type="checkbox"/> 200mg/1.14ml Prefilled Pen	<input type="checkbox"/> Inject once every TWO weeks	<input type="checkbox"/> 4 week supply	
<b>Kineret®</b>	<input type="checkbox"/> 100mg/0.67 ml Prefilled SYR	<input type="checkbox"/> Inject 100mg SC once daily	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Olumiant</b>	<input type="checkbox"/> 2 mg tabs	<input type="checkbox"/> Take 2 mg by mouth once daily	<input type="checkbox"/> tabs	
<b>Orencia®</b>	<input type="checkbox"/> 250mg Vial <input type="checkbox"/> 125mg/ml SYR <input type="checkbox"/> 125mg/ml Clickject <input type="checkbox"/> 50 mg SYRINGE (for children ≥ 2years and weighing 10kg to less than 25kg)	<input type="checkbox"/> IV dosage: Infuse _____ mg at weeks 0, 2, 4 then every 4 weeks thereafter <input type="checkbox"/> Subcutaneous dosage: Inject 125mg SC once a week	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Otezla®</b>	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 30 mg	Starter Kit: _____ Maintenance Dose: _____ <input type="checkbox"/> Take as directed <input type="checkbox"/> Twice Daily	<input type="checkbox"/> 4 week supply	
<b>Remicade®</b>	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> IV _____ mg at 0, 2, and 6 weeks (induction) <input type="checkbox"/> IV _____ mg every 8 weeks (maintenance) <input type="checkbox"/> IV every _____ weeks	<input type="checkbox"/> # of Vials	
<b>Renflexis™</b>	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Induction Dose: 5mg/kg (Dose _____ mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: 5mg/kg (Dose _____ mg) IV every 8 weeks <input type="checkbox"/> Other	<input type="checkbox"/> # of Vials	
<b>Rituxan®</b>	<input type="checkbox"/> 100mg/10ml Vial <input type="checkbox"/> 500mg/50ml Vial	Specified:	<input type="checkbox"/> # of Vials	
<b>Simponi®</b>	<input type="checkbox"/> 100mg/1ml SmartJect Autoinjector <input type="checkbox"/> 100mg/1ml Prefilled SYR <input type="checkbox"/> 50mg/0.5ml SmartJect Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled SYR	<input type="checkbox"/> Inject 100mg SC ONCE a month <input type="checkbox"/> Inject 50mg SC ONCE a month	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Taltz®</b>	<input type="checkbox"/> 80mg/ml single-dose Prefilled Autoinjector <input type="checkbox"/> 80mg/ml single-dose Prefilled SYR	<input type="checkbox"/> Inject 160mg SC at week 0 followed by 80mg every 4 weeks <input type="checkbox"/> Inject 80mg SC every 4 weeks	<input type="checkbox"/> 2 syringes/pens <input type="checkbox"/> 1 syringe/pen	
<b>Xeljanz®</b>	<input type="checkbox"/> 5mg tablet	<input type="checkbox"/> Twice Daily	<input type="checkbox"/> 4 week supply	
<b>Xeljanz XR®</b>	<input type="checkbox"/> 11mg tablet	<input type="checkbox"/> Take one tablet once a day	<input type="checkbox"/> 4 week supply	

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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