

# Asthma/Allergy Enrollment Form



www.noblehealthservices.com

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

## Signature Care Program

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:	
Social Security Number:		DEA/NPI#:	

### INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION	
Diagnosis:	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
ICD-10 Code:	Medications failed:
Height: _____ Weight: _____ feet inches lbs.	Medications on:
Allergies:	Other notes:

### PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
<b>Cinqair</b>	<input type="checkbox"/> 100MG/10ML VIAL	<input type="checkbox"/> Inject _____ mg (3mg/kg every 4 weeks IV infusion)	____ Vials <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other	
<b>Xolair®</b>	<input type="checkbox"/> 75 mg/0.5 mL in a single-dose prefilled syringe <input type="checkbox"/> 150 mg/mL solution in a single-dose prefilled syringe <input type="checkbox"/> 150 mg lyophilized powder in a single-dose vial for reconstitution	<input type="checkbox"/> Inject _____ mg every 2 weeks <input type="checkbox"/> Inject _____ mg every 4 weeks <input type="checkbox"/> Other	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other	
<b>Dupixent®</b>	<input type="checkbox"/> 200 mg/1.14 mL solution in a single-dose pre-filled syringe <input type="checkbox"/> 300 mg/2 mL solution in a single-dose pre-filled syringe	<b>Starting Dose:</b> <input type="checkbox"/> 400 mg (two 200 mg injections) <input type="checkbox"/> 600 mg (two 300 mg injections)  <b>Maintenance Dose:</b> <input type="checkbox"/> 200 mg every other week <input type="checkbox"/> 300 mg every other week	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other	
<b>Other:</b>				
<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

**Important Notice:** This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy.