

Dermatology Enrollment Form Medications A-M

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: <input type="checkbox"/> Atopic Dermatitis L20 <input type="checkbox"/> Psoriasis L40 <input type="checkbox"/> Psoriatic arthritis L40.5 <input type="checkbox"/> Hidradenitis Suppurativa L73.2 <input type="checkbox"/> Other	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last PPD Test M/D/Y <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: / /	Medications failed:
Height: _____ Weight: _____ feet inches lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Actemra®	<input type="checkbox"/> 162mg/0.9ml	<input type="checkbox"/> SC every OTHER week <input type="checkbox"/> SC every week <input type="checkbox"/> Other:	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
Cimzia®	<input type="checkbox"/> 200mg/ml Prefilled SYR <input type="checkbox"/> Starter Kit	Loading Dose: <input type="checkbox"/> Inject 400mg SC at weeks 0,2 and 4 <input type="checkbox"/> 400mg SC every 4 weeks Maintenance Dose: <input type="checkbox"/> 200mg SC every other week	<input type="checkbox"/> 4 week supply	
Cosentyx™ <i>*Enhanced Specialty Pharmacy Program Participant</i>	<input type="checkbox"/> 150mg Pen <input type="checkbox"/> 150mg SYR	Loading Dose: <input type="checkbox"/> 150mg 0,1,2,3,4 weeks <input type="checkbox"/> 150mg every 4 weeks <input type="checkbox"/> 300mg 0,1,2,3,4 weeks <input type="checkbox"/> 300mg every 4 weeks Maintenance Dose:	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other:	
Cosentyx™ <i>*Enhanced Specialty Pharmacy Program Participant</i> <i>Covered Until You're Covered</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"/> 150mg every 4 weeks <input type="checkbox"/> 300mg 0,1,2,3,4 weeks <input type="checkbox"/> 300mg every 4 weeks Maintenance Dose:	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other:	
Dupixent®	<input type="checkbox"/> 300mg/ml Prefilled SYR	Loading Dose: <input type="checkbox"/> Inject two 300mg SC once Maintenance Dose: <input type="checkbox"/> Inject 300mg every other week	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other:	
Enbrel®	<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:	
Humira HS Starter Kit	<input type="checkbox"/> 40mg/0.8ml Pen x6 (Starter Kit) <input type="checkbox"/> 80mg/0.8ml Pen x3 (Citrate-Free)	Loading Dose: <input type="checkbox"/> Inject 160 mg day 1, 80 mg day 15, maintenance beginning on day 29 OR <input type="checkbox"/> Inject 80 mg Day 1, 80mg Day 2, 80mg on Day 15, maintenance beginning on day 29	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
Humira® Psoriasis/Uveitis Starter Kit Citrate-Free	<input type="checkbox"/> 40mg/0.8ml Pen x4 (Starter Kit) <input type="checkbox"/> 80mg/0.8ml Pen x1, 40mg/0.4ml Pen x2 (Citrate-Free)	Loading Dose: <input type="checkbox"/> Inject 80 mg SC day 1, 40 mg day 8, 40 mg maintenance beginning on day 22	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
Humira®	<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:	
<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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Dermatology Enrollment Form Medications N-Z

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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

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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:
Otezla®	<input type="checkbox"/> 28 day starter pack titration <input type="checkbox"/> 30mg	<input type="checkbox"/> Initial dosage titration per starter pack <input type="checkbox"/> 30mg twice daily taken orally	<input type="checkbox"/> 1 month starter pack <input type="checkbox"/> Bottle of 60 <input type="checkbox"/> Other:	
Simponi®	<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:	
Siliq™	<input type="checkbox"/> 210mg/1.5ml Prefilled SYR	<input type="checkbox"/> Inject 210mg SC at weeks: 0, 1 and 2 and 210mg SC every 2 weeks thereafter	<input type="checkbox"/> Starter Dose (3 SYR) <input type="checkbox"/> Maintenance Dose (2 SYR)	
Stelara®	<input type="checkbox"/> 45mg/0.5ml Prefilled SYR <input type="checkbox"/> 90mg/ml Prefilled SYR	<input type="checkbox"/> Inject 45mg SC at 0 and 4 weeks, then every 12 weeks thereafter <input type="checkbox"/> Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter	<input type="checkbox"/> 2 SYR loading <input type="checkbox"/> 1 SYR maintenance	
Taltz®	<input type="checkbox"/> 80mg/ml single-dose Prefilled Autoinjector <input type="checkbox"/> 80mg/ml single-dose Prefilled SYR	Psoriasis Loading Dose: <input type="checkbox"/> Inject 160mg SC at week 0 followed by 80mg SC on weeks 2, 4, 6, 8, 10 and 12 <input type="checkbox"/> Maintenance Dose: Inject 80mg SC every 4 weeks Psoriatic Arthritis Loading Dose: <input type="checkbox"/> Inject 160mg SC at week 0 followed by 80mg every 4 weeks <input type="checkbox"/> Maintenance Dose: Inject 80mg SC every 4 weeks	<input type="checkbox"/> 3 syringes/pens <input type="checkbox"/> 2 syringes/pens <input type="checkbox"/> 1 syringe/pen	
Tremfya®	<input type="checkbox"/> 100mg/ml Prefilled SYR	<input type="checkbox"/> Inject mg at weeks 0, 4, then every 8 weeks thereafter	<input type="checkbox"/> Loading Dose/ 4 week supply <input type="checkbox"/> Maintenance/ 8 week supply	
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: _____

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