



# DERMATOLOGY

E-SCRIBE and FAX ENROLLMENT FORM

NOBLE NORTHEAST: E-Scribe: NOBLE | Fax: 888-842-3977 | Tel: 888-843-2040

NOBLE SOUTHEAST: E-Scribe: NOBLEMS/TRANSCRIPT | Fax: 601-420-4040 | Tel: 866-420-4041

Delivery Needed By: \_\_\_\_\_ Deliver to:  Patient's Home  Physician's Office  Other: \_\_\_\_\_

## PATIENT INFORMATION

## PRESCRIBER INFORMATION

Patient Name: \_\_\_\_\_ Male:  Prescriber: \_\_\_\_\_

Address: \_\_\_\_\_ Female:  Office Contact: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Last 4 of SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Translator: Yes  No  Language: \_\_\_\_\_ DEA/NPI #: \_\_\_\_\_

Patient interested in: Support Programs  Ancillary Supplies  Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## INSURANCE INFORMATION - PLEASE FAX A COPY OF FRONT & BACK OF PRESCRIPTION CARD

## CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Has the patient been treated previously for this condition: Yes  No  Height: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_ lbs

Allergies: \_\_\_\_\_ Medications On: \_\_\_\_\_

Other Notes: \_\_\_\_\_ Medications Failed: \_\_\_\_\_

## MEDICATION INFORMATION

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Actemra®  | <input type="checkbox"/> Hadlima® (Humira Biosimilar)                       | <input type="checkbox"/> Remicade®                    |
| <input type="checkbox"/> Adbry®  | <input type="checkbox"/> Humira® Citrate-free                               | <input type="checkbox"/> Renflexis®                   |
| <input type="checkbox"/> Amjevita® Citrate-free (Humira Biosimilar)                | <input type="checkbox"/> Humira® Citrate-free HS Starter Kit                | <input type="checkbox"/> Rinvoq®                      |
| <input type="checkbox"/> Bimzelx®  | <input type="checkbox"/> Humira® Citrate-free Psoriasis/Uveitis Starter Kit | <input type="checkbox"/> Siliq®                       |
| <input type="checkbox"/> Botox®  | <input type="checkbox"/> Hyrimoz® (Humira Biosimilar)                       | <input type="checkbox"/> Simponi®                     |
| <input type="checkbox"/> Cibinqo®  | <input type="checkbox"/> Ilumya®  | <input type="checkbox"/> Skyrizi®                     |
| <input type="checkbox"/> Cimzia®   | <input type="checkbox"/> Inflectra®   | <input type="checkbox"/> Sotyktu®                     |
| <input type="checkbox"/> Cosentyx®   | <input type="checkbox"/> Olumiant®  | <input type="checkbox"/> Stelara®                     |
| <input type="checkbox"/> Cyltezo® Citrate-free (Humira Interchangeable Biosimilar) | <input type="checkbox"/> Opzelura®  | <input type="checkbox"/> Taltz®                       |
| <input type="checkbox"/> Duobril®  | <input type="checkbox"/> Otezla®  | <input type="checkbox"/> Tremfya®                     |
| <input type="checkbox"/> Dupixent®   | <input type="checkbox"/> Otrexup®   | <input type="checkbox"/> Vtama®                       |
| <input type="checkbox"/> Enbrel®   | <input type="checkbox"/> Rasuvo®  | <input type="checkbox"/> Yuflyma® (Humira Biosimilar) |
| <input type="checkbox"/> Enbrel® Mini  | <input type="checkbox"/> Rayos®   | <input type="checkbox"/> Other: _____                 |

Dosage/Strength:	Route of Administration:	Directions:	Quantity:	Refills:	Dispense as Written:
	<input type="checkbox"/> Pen <input type="checkbox"/> Starter Kit <input type="checkbox"/> Syringe <input type="checkbox"/> Tablet <input type="checkbox"/> Topical <input type="checkbox"/> Vial				

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