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**

Psoriasis

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:
Cimzia	☐ 200mg syringe ☐ 200 mg single-dose vial	Loading Dose: ☐ Inject 400 mg SC 0,2,4 weeks followed by 200mg every other week ☐ Inject 400mg SC every other week ☐ Inject 400mg SC 0, 2, 4 weeks	Maintenance Dose: ☐ Inject 400 mg SC every 4 weeks ☐ Inject 200 mg SC every other week	☐ 4 week supply ☐ Other	
Cosentyx ™ **Enhanced Specialty Pharmacy Program Participant*	☐ 150mg pen ☐ 150mg syringe	Loading Dose: ☐ Inject 300mg SC 0,1,2,3,4 weeks	Maintenance Dose: ☐ Inject 300mg SC every 4 weeks	☐ 4 week supply (maintenance) ☐ 5 week supply (loading) ☐ Other	
Cosentyx ™ **Enhanced Specialty Pharmacy Program Participant Covered Until You're Covered*	☐ 150mg pen ☐ 150mg syringe	Loading Dose: ☐ Inject 300mg SC 0,1,2,3,4 weeks	Maintenance Dose: ☐ Inject 300mg SC every 4 weeks	☐ 4 week supply (maintenance) ☐ 5 week supply (loading) ☐ Other	
Enbrel®	☐ 50mg/ml single-use prefilled syringe ☐ 50mg/ml SureClick Autoinjector ☐ 25mg/0.5ml Prefilled syringe ☐ 25mg Vial	Loading Dose: ☐ Inject 50mg SC TWICE a week (72-96 hours apart) for three months then maintenance dosing	Maintenance Dose: ☐ Inject 50mg SC ONCE a week	☐ 4 week supply ☐ Other	
Humira® Psoriasis-Starter Kit	**Standard:** ☐ 40mg/0.8ml Pen x4 (Starter Kit) **Citrate Free:** ☐ 80mg/0.8ml Pen x1, 40mg/0.4ml Pen x2 (Citrate-Free)	Loading Dose: ☐ Inject 80 mg SC day 1, 40 mg day 8, 40 mg maintenance beginning on day 22		☐ 4 week supply ☐ Other	
Humira®	**Standard:** ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled SYR Citrate-Free: ☐ 40mg/0.4ml Pen (Citrate-Free) ☐ 40mg/0.4ml Prefilled SYR (Citrate-Free)	☐ Inject 40mg SC every OTHER week		☐ 4 week supply ☐ Other	
Ilumya	☐ 100 mg/ml Prefilled syringe	Loading Dose: ☐ Inject 100 mg SC at Weeks 0, and 4, then every 12 weeks thereafter	Maintenance Dose: ☐ Inject 100 mg SC every 12 Weeks	☐ _____ Vials ☐ 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 ☐ IV ___ mg every __ weeks	☐ _____ Vials ☐ Other	

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

Physician Signature: _____ Date: _____

Psoriasis

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:
Otezla	☐ 28 Day Starter Pack Titration ☐ 30mg tablet	Induction Dose: ☐ Titration per starter pack Maintenance Dose: ☐ Take 30 mg by mouth twice daily	☐ 1 Month Starter Pack ☐ Bottle of 60 ☐ Other	
Otrexup	☐ 10 mg/0.4ml ☐ 17.5 mg/0.4ml ☐ 12.5 mg/0.4ml ☐ 20 mg/0.4 ml ☐ 15 mg/0.4 ml ☐ 22.5 mg/0.4ml ☐ 25 mg/0.4ml ☐ *Prefilled Autoinjector*	☐ Inject _____ mg SC once weekly	☐ _____ Prefilled Autoinjector(s) ☐ Other	
Rasuvo	☐ 7.5 mg /0.15ml ☐ 20 mg/0.4ml ☐ 10 mg/0.2ml ☐ 22.5 mg/0.45ml ☐ 12.5 mg /0.25ml ☐ 25 mg /0.5ml ☐ 15 mg /0.3ml ☐ 27.5 mg/0.55ml ☐ 17.5 mg/0.35ml ☐ 30 mg/0.6ml ☐ *Prefilled Autoinjector*	☐ Inject _____ mg SC once weekly	☐ _____ Prefilled Autoinjector(s) ☐ Other	
Rayos	☐ 1 mg Tablet ☐ 2 mg Tablet ☐ 5 mg Tablet	☐ Take ____ mg by mouth daily	☐ _____ Day Supply ☐ 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 ☐ Other	
Renflexis	☐ 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 ☐ Other	
Siliq	☐ 210mg/1.5 ml Prefilled syringe	☐ Inject 219 mg SC at weeks 0, 1 and 2 and 210 mg SC every 2 weeks thereafter	☐ Starter Dose (3 SYR) ☐ Maintenance Dose (2 SYR) ☐ Other	
Stelara	☐ 45 mg/ 0.5ml Prefilled syringe ☐ 90 mg/ml Prefilled syringe	☐ Patients weighing 100kg: Inject 90mg 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 ☐ Other	
Taltz	☐ 80mg/ml single-dose Prefilled Autoinjector ☐ 80mg/ml single-dose Prefilled syringe	Loading Dose: ☐ Inject 160 mg SC at week 0 followed by 80 mg SC on weeks 2,4,6,8, 10 and 12 Maintenance Dose: ☐ Inject 80 mg SC every 4 weeks	☐ 3 SYR/Pens ☐ 2 SYR/Pens ☐ 1 SYR/Pens ☐ Other	
Tremfya	☐ 100 mg/ml prefilled syringe ☐ 100 mg/ml autoinjector	☐ Inject _____ mg SC at weeks 0, 4, then every 8 weeks thereafter	☐ Loading Dose/ 4 week supply ☐ Maintenance Dose 8 Week Supply ☐ Other	
Skyrizi	☐ 75mg/0.83mL prefilled syringe	Loading Dose: ☐ Inject 150 mg (2-75mg syringes) SC at weeks 0, 4, and every 12 weeks thereafter Maintenance Dose: ☐ Inject 150 mg SC every 12 weeks	☐ 4 week supply ☐ Other	
Other				

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

Physician Signature: _____ Date: _____