

Hepatitis C Enrollment Form



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:	
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: <input type="checkbox"/> B17.1 <input type="checkbox"/> B17.11 <input type="checkbox"/> B17.10 <input type="checkbox"/> B18.2 <input type="checkbox"/> B19.2 <input type="checkbox"/> B19.21 <input type="checkbox"/> B19.20 <input type="checkbox"/> Z22.52 <input type="checkbox"/> Other	Medications failed:
Height: _____ Weight: _____ feet inches lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Daklinza™	<input type="checkbox"/> 30mg tablet <input type="checkbox"/> 60mg tablet <input type="checkbox"/> 90mg tablet	<input type="checkbox"/> Specified:	4 week supply	
Eplus™	400-100mg tablets	<input type="checkbox"/> Take tablet(s) by mouth times daily	4 week supply	
Harvoni®	90-400mg tablets	<input type="checkbox"/> Take tablet(s) by mouth times daily	4 week supply	
Mavyret™	100/40 mg	<input type="checkbox"/> Take tablet(s) by mouth times daily with food	4 week supply	
Olysio™	150mg capsules	<input type="checkbox"/> Take capsule(s) by mouth times daily	4 week supply	
Ribavirin™	<input type="checkbox"/> 200mg tablets <input type="checkbox"/> 200mg capsules	<input type="checkbox"/> Take tablet(s) by mouth times daily <input type="checkbox"/> Take capsule(s) by mouth times daily	4 week supply	
Sovaldi®	400mg tablets	<input type="checkbox"/> Take tablet(s) by mouth times daily	4 week supply	
Viekira Pak™	12.5/75/50 – 250mg Dosepack	<input type="checkbox"/> Take two 12.7/75/50mg tablets by mouth once daily every morning, and one 250mg tablet by mouth twice daily (morning and evening) with meal	4 week supply	
Viekira XR™	8.33/50/33.33 – 200mg Dosepack	<input type="checkbox"/> Take tablet(s) by mouth times daily	4 week supply	
Vosevi™	400/100/100mg	<input type="checkbox"/> Take tablet(s) by mouth once daily with food	4 week supply	
Zepatier™	50mg/100mg tablets	<input type="checkbox"/> One tablet taken orally once daily with or without food	4 week supply	
Other:				

Patient is interested in patient support programs

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.