# Rheumatology Enrollment Form Medications A-H

www.noblehealthservices.com

NOBLE HEALTH SERVICES
A SPECIALTY PHARMACY

***Signature Care Program***


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


Delivery Need By: Delivery to: ☐Patients Home ☐Physician's Office ☐Other

| PATIENT INFORMATION | PRESCRIBER INFORMATION |
|---|---|
| Patient Name: ☐Female ☐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/ ICD-10 Code: | Has the patient been treated previously for this condition? ☐ Yes ☐ No |
| Last PPD Test M/D/Y ☐ Positive ☐ Negative Date: / / | Medications failed: |
| Height: feet inches Weight: lbs. | Medications on: |
| Allergies: | Other notes: |

**PRESCRIPTION INFORMATION**

| Medication: | Dosage/Strength: | Directions: | Quantity: | Refills: |
|---|---|---|---|---|
| **Actemra®** | ☐ 162mg/0.9ml | ☐ SC every OTHER week<br>☐ SC every week<br>☐ Other: | ☐ 4 week supply<br>☐ Other: | |
| **Cimzia®** | ☐ 200mg/ml Prefilled SYR<br>☐ Starter Kit | ☐ Initial Dose: Inject 400mg SC at weeks 0,2, and 4, then:<br>Maintenance Dose:<br>☐ 200mg SC every other week OR<br>☐ 400mg SC every 4 weeks | ☐ 4 week supply | |
| **Cosentyx ™**<br>**Enhanced Specialty Pharmacy Program Participant* | ☐ 150mg Pen<br>☐ 150mg Syringe | Loading Dose:<br>☐ 150mg 0,1,2,3,4 weeks<br>☐ 300mg 0,1,2,3,4 weeks<br>Maintenance Dose:<br>☐ 150mg every 4 weeks<br>☐ 300mg every 4 weeks | ☐ 4 week supply (maintenance)<br>☐ 5 week supply (loading)<br>☐ Other: | |
| **Cosentyx ™**<br>**Enhanced Specialty Pharmacy Program Participant*<br>***Covered Until You're Covered*** | ☐ 150mg Pen<br>☐ 150mg Syringe | Loading Dose:<br>☐ 150mg 0,1,2,3,4 weeks<br>☐ 300mg 0,1,2,3,4 weeks<br>Maintenance Dose:<br>☐ 150mg every 4 weeks<br>☐ 300mg every 4 weeks | ☐ 4 week supply (maintenance)<br>☐ 5 week supply (loading)<br>☐ Other: | |
| **Enbrel®** | ☐ 50mg/ml Single Use Prefilled SYR<br>☐ 50mg/ml SureClick AutoInjector<br>☐ 25mg/0.5ml Prefilled SYR<br>☐ 25mg Vial | ☐ Inject 50mg SC TWICE a week (72-96 hours apart)<br>☐ Inject 50mg SC ONCE a week<br>☐ Inject 25mg SC TWICE a week (72-96 hours apart)<br>☐ Other: | ☐ 4 week supply<br>☐ Other: | |
| **Humira®** | ☐ 40mg/0.8ml Pen<br>☐ 40mg/0.8ml Prefilled SYR<br>☐ 40mg/0.4ml Pen **(Citrate-Free)**<br>☐ 40mg/0.4ml Prefilled SYR **(Citrate-Free)** | ☐ Inject 40mg SC every OTHER week<br>☐ Inject 40mg SC ONCE a week | ☐ 4 week supply<br>☐ 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

# Rheumatology Enrollment Form Medications I-Z

www.noblehealthservices.com

NOBLE HEALTH SERVICES
A SPECIALTY PHARMACY

***Signature Care Program***


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


Delivery Need By: Delivery to: ☐Patients Home ☐Physician's Office ☐Other

| PATIENT INFORMATION | PRESCRIBER INFORMATION |
|---|---|
| Patient Name: ☐Female ☐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/ ICD-10 Code: | Has the patient been treated previously for this condition? ☐ Yes ☐ No |
| Last PPD Test M/D/Y ☐ Positive ☐ Negative Date: / / | Medications failed: |
| Height: feet inches Weight: lbs. | Medications on: |
| Allergies: | Other notes: |

**PRESCRIPTION INFORMATION**

| Medication: | Dosage/Strength: | Directions: | Quantity: | Refills: |
|---|---|---|---|---|
| **Kevzara®** | ☐ 150mg/1.14ml Prefilled SYR<br>☐ 150mg/1.14ml Prefilled Pen<br>☐ 200mg/1.14ml Prefilled SYR<br>☐ 200mg/1.14ml Prefilled Pen | ☐ Inject once every TWO weeks | ☐ 4 week supply | |
| **Kineret®** | ☐ 100mg/0.67 ml Prefilled SYR | ☐ Inject 100mg SC once daily | ☐ 4 week supply<br>☐ Other: | |
| **Orencia®** | ☐ 250mg Vial<br>☐ 125mg/ml SYR<br>☐ 125mg/ml Clickject | ☐ Infuse mg at weeks 0, 2, 4 then every 4 weeks thereafter<br>☐ Inject 125mg once a week | ☐ 4 week supply<br>☐ Other: | |
| **Otezla®** | ☐ Starter Kit<br>☐ 30 mg | Starter Kit: Maintenance Dose:<br>☐ Take as directed ☐ Twice Daily | ☐ 4 week supply | |
| **Remicade®** | ☐ 100mg Vial | ☐ IV mg at 0, 2, and 6 weeks (induction)<br>☐ IV mg every 8 weeks (maintenance)<br>☐ IV every weeks | ☐ # of Vials | |
| **Rituxan®** | ☐ 100mg/10ml Vial<br>☐ 500mg/50ml Vial | Specified: | ☐ # of Vials | |
| **Simponi®** | ☐ 100mg/1ml SmartJect AutoInjector<br>☐ 100mg/1ml Prefilled SYR<br>☐ 50mg/0.5ml SmartJect AutoInjector<br>☐ 50mg/0.5ml Prefilled SYR | ☐ Inject 100mg SC ONCE a month<br>☐ Inject 50mg SC ONCE a month | ☐ 4 week supply<br>☐ Other: | |
| **Taltz ®** | ☐ 80mg/ml single-dose Prefilled Autoinjector<br>☐ 80mg/ml single-dose Prefilled SYR | ☐ Inject 160mg SC at week 0 followed by 80mg every 4 weeks<br>☐ Inject 80mg SC every 4 weeks | ☐ 2 syringes/pens<br>☐ 1 syringe/pen | |
| **Xeljanz ®** | ☐ 5mg tablet | ☐ Twice Daily | ☐ 4 week supply | |
| **Xeljanz XR ®** | ☐ 11mg tablet | ☐ Take one tablet once a day | ☐ 4 week supply | |

☐ 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