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**

Autoimmune

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:
Actemra®	☐ 162 mg/0.9 ml	☐ Inject SC every OTHER week ☐ Inject SC every week ☐ Other	☐ 4 week supply ☐ Other	
Cimzia®	☐ 200 mg/ml Prefilled SYR ☐ Starter Kit	Loading Dose: ☐ Inject 400 mg SC at weeks 0, 2 and 4 Maintenance Dose: ☐ Inject 200 mg SC every other week ☐ Inject 400 mg SC every 4 weeks ☐ Other	☐ 4 week supply ☐ Other	
Enbrel® *Enbrel Mini Available*	☐ 50 mg/ml Single Use Prefilled SYR ☐ 50 mg/ml SureClick AutoInjector ☐ 25 mg/0.5 ml Prefilled SYR ☐ 25 mg Vial	☐ Inject 50mg SC twice a week (72-96 Hours apart) ☐ Inject 50mg SC once a week ☐ Inject 25 mg SC twice a week (72-96 hours apart) ☐ Other	☐ 4 week supply ☐ Other	
Humira® *Humira® Citrate-Free Available*	Standard: ☐ 40 mg/0.8ml Pen ☐ 40 mg/0.8ml Prefilled Syringe Citrate-Free: ☐ 40mg/0.4 ml Pen ☐ 40 mg/0.4 ml Prefilled SYR	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC once a week ☐ Other	☐ 4 week supply ☐ Other	
Orencia®	☐ 250 mg Vial ☐ 125 mg/ml SYR ☐ 125 mg/ml Clickject	☐ Infuse _____ mg at weeks 0, 2, 4 then every 4 weeks thereafter ☐ Inject 125 mg SC once a week ☐ Other	☐ 4 week supply ☐ Other	
Otezla®	☐ 30 mg tablet ☐ Starter Kit	☐ Take one tablet by mouth Twice Daily ☐ Use directions on starter kit ☐ Other:	☐ 4 week supply ☐ Other	

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

Physician Signature: _____ Date: _____

Autoimmune

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:
Remicade®	☐ 100 mg vial	Induction Dose: ☐ IV _____ mg at 0, 2 and 6 weeks Maintenance Dose: ☐ IV____ every 8 weeks ☐ IV _____ every _____ weeks ☐ Other	☐ _____ # of Vials	
Rituxan®	☐ 100 mg/10 ml Vial ☐ 500 mg/ 50 ml Vial	☐ Specified	☐ _____ of Vials	
Simponi®	☐ 100mg/1ml SmartJect Autoinjector ☐ 100 mg/1 ml Prefilled SYR ☐ 50mg/0.5 ml SmartJect Autoinjector ☐ 50mg/ ml Prefilled Syringe	☐ Inject 100 mg SC ONCE a month ☐ Inject 50 mg SC ONCE a month ☐ Other	☐ 4 week supply ☐ Other	
Tremfya®	☐ 100 mg/mg Prefilled SYR	☐ Inject _____ SC at weeks 0,4, then every 8 weeks thereafter ☐ Other	☐ Loading Dose/ 4 week supply ☐ Maintenance/ 8 week supply ☐ Other	
Xeljanz®	☐ 5mg tablet	☐ Take one tablet by mouth twice daily ☐ Other	☐ 4 week supply ☐ Other	
Xeljanz XR®	☐ 11 mg tablet	☐ Take one tablet by mouth once a day ☐ Other	☐ 4 week supply ☐ Other	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____