Rheumatology Enrollment Form Medications A-I

www.noblehealthservices.com

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 Prefilled syringe ☐ 80 mg/4ml Vial ☐ 200mg/10ml Vial ☐ 400mg/20ml Vial	☐ SC every OTHER week ☐ SC every week ☐ Induction dose: 4mg/kg (_____mg dose) every 4 weeks. ☐ Maintenance dose: 8mg/kg (_____mg dose) every 4 weeks.	☐ 4 week supply ☐ Other:	
Cimzia®	☐ 200mg/ml Prefilled SYR ☐ Starter Kit	☐ Initial Dose: Inject 400mg SC at weeks 0,2, and 4, then: Maintenance Dose: ☐ 200mg SC every other week OR ☐ 400mg SC every 4 weeks	☐ 4 week supply	
Cosentyx ™ **Enhanced Specialty Pharmacy Program Participant*	☐ 150mg Pen ☐ 150mg Syringe	Loading Dose: ☐ 150mg 0,1,2,3,4 weeks ☐ 300mg 0,1,2,3,4 weeks Maintenance Dose: ☐ 150mg every 4 weeks ☐ 300mg 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 Syringes	Loading Dose: ☐ 150mg 0,1,2,3,4 weeks ☐ 300mg 0,1,2,3,4 weeks Maintenance Dose: ☐ 150mg every 4 weeks ☐ 300mg every 4 weeks	☐ 4 week supply (maintenance) ☐ 5 week supply (loading) ☐ Other:	
Enbrel®	☐ 50mg/ml Single Use Prefilled SYR ☐ 50mg/ml SureClick AutoInjector ☐ 25mg/0.5ml Prefilled SYR ☐ 25mg Vial	☐ Inject 50mg SC TWICE a week (72-96 hours apart) ☐ Inject 50mg SC ONCE a week ☐ Inject 25mg SC TWICE a week (72-96 hours apart) ☐ Other:	☐ 4 week supply ☐ Other:	
Humira®	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled SYR ☐ 40mg/0.4ml Pen **(Citrate-Free)** ☐ 40mg/0.4ml Prefilled SYR **(Citrate-Free)**	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	☐ 4 week supply ☐ Other:	
Inflectra ®	☐ 100 MG VIAL	☐Induction 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 ☐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

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Rheumatology Enrollment Form Medications J-Z

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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#:

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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 ☐ 150mg/1.14ml Prefilled Pen ☐ 200mg/1.14ml Prefilled SYR ☐ 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 ☐ Other:	
Olumniant	☐ 2 mg tabs	☐ Take 2 mg by mouth once daily	☐ tabs	
Orencia®	☐ 250mg Vial ☐ 125mg/ml SYR ☐ 125mg/ml Clickject ☐ 50 mg SYRINGE (for children ≥ 2years and weighing 10kg to less than 25kg	☐ IV dosage: Infuse mg at weeks 0, 2, 4 then every 4 weeks thereafter ☐ Subcutaneous dosage: Inject 125mg SC once a week	☐ 4 week supply ☐ Other:	
Otezla®	☐ Starter Kit ☐ 30 mg	Starter Kit: ☐ Take as directed Maintenance Dose: ☐ Twice Daily	☐ 4 week supply	
Remicade®	☐ 100mg Vial	☐ IV mg at 0, 2, and 6 weeks (induction) ☐ IV mg every 8 weeks (maintenance) ☐ IV every weeks	☐ # of Vials	
Renflexis™	☐ 100mg Vial	☐ Induction 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 ☐ Other_______________________________________	☐ # of Vials	
Rituxan®	☐ 100mg/10ml Vial ☐ 500mg/50ml Vial	Specified:	☐ # of Vials	
Simponi®	☐ 100mg/1ml SmartJect AutoInjector ☐ 100mg/1ml Prefilled SYR ☐ 50mg/0.5ml SmartJect AutoInjector ☐ 50mg/0.5ml Prefilled SYR	☐ Inject 100mg SC ONCE a month ☐ Inject 50mg SC ONCE a month	☐ 4 week supply ☐ Other:	
Taltz ®	☐ 80mg/ml single-dose Prefilled Autoinjector ☐ 80mg/ml single-dose Prefilled SYR	☐ Inject 160mg SC at week 0 followed by 80mg every 4 weeks ☐ Inject 80mg SC every 4 weeks	☐ 2 syringes/pens ☐ 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: ___________

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