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**

Cystic Fibrosis

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

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:
Bethkis	☐ 300 mg/4ml ampule	☐ Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug	☐ 4 Week Supply	
Kitabis Pak	☐ 300 mg/5ml ampule	☐ Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug	☐ 4 week supply	
Pulmozyme	☐ 2.5 mg ampule	☐ Administer contents of one ampule once daily ☐ Administer contents of one ampule twice daily	☐ 30 Ampules ☐ 60 Ampules	
Tobramycin	☐ 300mg/5ml ampule	☐ Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug	☐ 4 week supply	
Other				

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

Physician Signature: ___________________________________ Date: __________________________

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