



RHEUMATOLOGY

E-SCRIBE and FAX ENROLLMENT FORM

NOBLE NORTHEAST: E-Scribe: **NOBLE** | Fax: **888-842-3977** | Tel: 888-843-2040

NOBLE SOUTHEAST: E-Scribe: **NOBLEMS/TRANSCRIPT** | Fax: **601-420-4040** | Tel: 866-420-4041

Delivery Needed By: _____ Deliver to: Patient's Home Physician's Office Other: _____

PATIENT INFORMATION

Patient Name: _____ Male: Prescriber: _____
 Address: _____ Female: Office Contact: _____
 City: _____ State: _____ Zip: _____ Address: _____
 Phone: _____ Email: _____ City: _____ State: _____ Zip: _____
 Last 4 of SSN: _____ DOB: _____ Phone: _____ Fax: _____
 Translator: Yes No Language: _____ DEA/NPI #: _____
 Patient interested in: Support Programs Ancillary Supplies Signature: _____ Date: _____

PRESCRIBER INFORMATION

INSURANCE INFORMATION - PLEASE FAX A COPY OF FRONT & BACK OF PRESCRIPTION CARD

CLINICAL INFORMATION

Diagnosis: _____ ICD-10 Code: _____
 Has the patient been treated previously for this condition: Yes No Height: _____ ft _____ in Weight: _____ lbs
 Allergies: _____ Medications On: _____
 Other Notes: _____ Medications Failed: _____

MEDICATION INFORMATION

- | | | |
|--|---|---|
| <input type="checkbox"/> Actemra® | <input type="checkbox"/> Hyrimoz® (Humira Biosimilar) | <input type="checkbox"/> Rinvoq® |
| <input type="checkbox"/> Amjevita® Citrate-free (Humira Biosimilar) | <input type="checkbox"/> Ilaris® | <input type="checkbox"/> Rituxan® |
| <input type="checkbox"/> Cimzia® | <input type="checkbox"/> Inflectra® | <input type="checkbox"/> Simponi® |
| <input type="checkbox"/> Cosentyx® | <input type="checkbox"/> Kevzara® | <input type="checkbox"/> Simponi Aria® |
| <input type="checkbox"/> Cuprimine® (penicillamine) | <input type="checkbox"/> Olumiant® | <input type="checkbox"/> Skyrizi® |
| <input type="checkbox"/> Cyltezo® Citrate-free (Humira Interchangeable Biosimilar) | <input type="checkbox"/> Orencia® | <input type="checkbox"/> Taltz® |
| <input type="checkbox"/> Depen (penicillamine) | <input type="checkbox"/> Otezla® | <input type="checkbox"/> Tremfya® |
| <input type="checkbox"/> Enbrel® | <input type="checkbox"/> Otrexup® | <input type="checkbox"/> Xeljanz® |
| <input type="checkbox"/> Enbrel® Mini | <input type="checkbox"/> Rasuvo® | <input type="checkbox"/> Xeljanz XR® |
| <input type="checkbox"/> Hadlima® (Humira Biosimilar) | <input type="checkbox"/> Rayos® | <input type="checkbox"/> Yuflyma® (Humira Biosimilar) |
| | <input type="checkbox"/> Remicade® | <input type="checkbox"/> Other: _____ |

Dosage/Strength:	Route of Administration:	Directions:	Quantity:	Refills:	Dispense as Written:
	<input type="checkbox"/> Pen <input type="checkbox"/> Starter Kit <input type="checkbox"/> Syringe <input type="checkbox"/> Tablet <input type="checkbox"/> Topical <input type="checkbox"/> Vial				

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