NOBLE HEALTH SERVICES

IMMUNE DEFICIENCIES

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	PROVIDER INFORMATION
Patient Name: _____ ☐ Male	Prescriber's Name: _____
Street Address: _____ ☐ Female	Office Contact Name: _____
City: _____ State: ____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: ____ Zip Code: _____
Email Address: _____	Phone Number: _____
Last Four of Social: _____ Date of Birth: _____	Fax Number: _____
Translator Needed: ☐ Yes ☐ No Language: _____	DEA/NPI #: _____

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

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins 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:
Bivigam	☐ 10% (100mg/ml) Solution - 5g vial ☐ 10% (100mg/ml) Solution - 10g vial			
Cytogam	☐ 50 mg/ml single-dose vial			
Flebogamma DIF	☐ 5% (50mg/ml) solution - 2.5g vial ☐ 5% (50mg/ml) solution - 5g vial ☐ 5% (50mg/ml) solution - 10g vial ☐ 5% (50mg/ml) solution - 20g vial ☐ 10% (100mg/ml) solution - 5g vial ☐ 10% (100mg/ml) solution - 10g vial ☐ 10% (100mg/ml) solution - 20g vial			
GamaSTAN S/D	☐ 2ml single dose vial ☐ 10ml single dose vial			
Gammagard	☐ 10% (100mg/ml) solution - 1g vial ☐ 10% (100mg/ml) solution - 2.5g vial ☐ 10% (100mg/ml) solution - 5g vial ☐ 10% (100mg/ml) solution - 10g vial ☐ 10% (100mg/ml) solution- 20g vial ☐ 10% (100mg/ml) solution - 30g vial		☐ 1 month supply ☐ 90-day supply	☐ 1 refill annually
Gammagard S/D	☐ 200/25/300mg tablet		☐ 1 month supply ☐ 90-day supply	☐ 1 refill annually
Gammaked	☐ 10% (100mg/ml) solution - 1g vial ☐ 10% (100mg/ml) solution - 2.5g vial ☐ 10% (100mg/ml) solution - 5g vial ☐ 10% (100mg/ml) solution - 10g vial ☐ 10% (100mg/ml) solution - 20g vial			

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

Physician Signature: _____ Date: _____

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City: _____ State: _____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: _____ Zip Code: _____
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Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Gammaplex	☐ 5% (50mg/ml) solution - 5g vial ☐ 5% (50mg/ml) solution - 10g vial ☐ 5% (50mg/ml) solution - 20g vial ☐ 10% (100 mg/ml) solution - 5g vial ☐ 10% (100 mg/ml) solution - 10g vial ☐ 10% (100 mg/ml) solution - 20g vial			
Gamunex -C	☐ 10% (100mg/ml) solution - 1g vial ☐ 10% (100mg/ml) solution - 2.5g vial ☐ 10% (100mg/ml) solution - 5g vial ☐ 10% (100mg/ml) solution - 10gvial ☐ 10% (100mg/ml) solution - 20g vial ☐ 10% (100mg/ml) solution - 40g vial			
Hizentra	☐ 20% (200mg/ml) - 1g vial ☐ 20% (200mg/ml) - 2g vial ☐ 20% (200mg/ml) - 4g vial ☐ 20% (200mg/ml) - 10g vial			
HyperHEP B S/D	☐ 0.5ml neonatal single-dose prefilled syringe ☐ 1ml single-dose prefilled syringe ☐ 5ml single-dose vial			
HypeRHO S/D	☐ 1500 IU (300mcg) prefilled syringe (full dose) ☐ 250 IU (50mcg) prefilled syringe (mini dose)			
MICRhoGAM Ultra-Filtered Plus	☐ 250 IU (50mcg) prefilled syringe			

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Phone Number: _____	City: _____ State: _____ Zip Code: _____
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Allergies: _____

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☐ Yes ☐ No

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Medications On: _____

Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Octagam	☐ 5% (50mg/1ml) liquid- 1g single-use bottle ☐ 5% (50mg/1ml) liquid- 2.5g single-use bottle ☐ 5% (50mg/1ml) liquid- 5g single-use bottle ☐ 5% (50mg/1ml) liquid- 10g single-use bottle ☐ 5% (50mg/1ml) liquid- 25g single-use bottle ☐ 10% (100mg/ml) liquid- 2g single-use bottle ☐ 10% (100mg/ml) liquid- 5g single-use bottle ☐ 10% (100mg/ml) liquid- 10g single-use bottle ☐ 10% (100mg/ml) liquid- 20g single-use bottle			
Privigen	☐ 10% (100mg/ml) liquid - 5g vial ☐ 10% (100mg/ml) liquid - 10g vial ☐ 10% (100mg/ml) liquid - 20g vial ☐ 10% (100mg/ml) liquid - 40g vial			
RhoGAM Ultra-Filtered Plus	☐ 1500 IU (300mcg) prefilled syringe			
Rhophylac	☐ 1500 IU (300mcg) prefilled syringe			
Varizig	☐ 125 IU/1.2ml single-use vial			
WinRho SDF	☐ 600 IU single-dose vial ☐ 1,500 IU single-dose vial ☐ 2,500 IU single-dose vial ☐ 5,000 IU single-dose vial ☐ 15,000 IU single-dose vial			

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Physician Signature: _____ Date: _____

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Phone Number: _____	City: _____ State: _____ Zip Code: _____
Email Address: _____	Phone Number: _____
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Diagnosis: _____

ICD-10 Code: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Medications Failed: _____

Medications On: _____

Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Zinplava	☐ 1000 mg/40 ml single dose vial			
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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