Crohn's Disease / Ulcerative Colitis
Patient Enrollment & Prescription Form

Tel: 844-443-6879 Fax: 844-329-2447

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Medina, Ohio.

PATIENT INFORMATION

Patient Name _____

DOB ___/___/_____ SSN _____ Gender_____

Weight _____ Height _____ Phone _____

Address _____

City, State, Zip _____

Cell Phone _____ E-Mail _____

PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name _____

Insurance Co. Phone _____ Group# _____

Policy Holder Name _____

Policy Holder Employer _____

Relationship to Patient _____

ID# _____ RxBIN _____ PCN_____

PRESCRIBER INFORMATION

Prescriber's Name _____

Practice Name _____

State License#_____ UPIN _____

DEA _____ NPI _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Office Contact Person _____

Prescription Date _____ Date Needed _____

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber Signature _____

Ship to: ☐Patient ☐Prescriber's Office ☐Discount Drug Mart

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis _____ Date of Diagnosis _____

ICD-10 Code: _____ New to therapy? ☐ YES ☐ NO

TB negative? ☐ YES ☐ NO Hepatitis B negative? ☐ YES ☐ NO

Drug Allergies _____ Latex Allergy? ☐ YES ☐ NO

Prior Crohn's Therapy and for how long? _____

Reason for Discontinuation? _____

Any other relevant medical info? _____

PRESCRIPTION INFORMATION *(DAW requests must be handwritten)*

☐ **Cimzia® (certolizumab)** ☐ 200mg/1ml Prefilled Syringe Starter Kit

Directions: Inject 400 mg SQ initially and at Weeks 2 and 4 Qty: 6 Refills 0

☐ 200mg/1ml Prefilled Syringe for Maintenance Dosing

Directions: ☐ Inject 400 mg SQ every 4 wks **OR** ☐ Inject 400 mg SQ every 2 wks Qty: QS 30 Days Refills _____

☐ **Humira® (adalimumab)** ☐ Crohn's 40mg Starter Package

Directions: Inject 160 mg SQ initially followed by 80mg two weeks later (Day 15) Qty: 6 Refills 0

☐ 40mg Prefilled Pen Carton for Maintenance Dosing

Directions: Inject 40mg every other week Qty: QS 30 Days Refills _____

☐ **Remicade® (infliximab)** ☐ 100mg/20ml Vial Qty: QS 30 Days Refills _____

Directions: ☐ Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks **OR** ☐ Infuse 10mg/kg at 0, 2 and 6 weeks, then every 8 weeks

☐ **Simponi® (golimumab)** TYPE: ☐Smartject® Autoinjector ☐ Prefilled Syringe STRENGTH: ☐100mg

Directions: Inj 200 mg SQ initially at Week 0, followed by 100 mg at Week 2, then 100 mg every 4 weeks Qty: QS 30 Days Refills _____

☐ **Stelara® (ustekinumab)** ☐130mg Single Dose Vial ☐90mg single-dose prefilled syringe

☐ 260mg Starter (up to 55kg): Infuse intravenously over a period of at least one hour as directed

☐ 390mg Starter (greater than 55kg to 85kg): Infuse intravenously over a period of at least one hour as directed

☐ 520mg Starter (greater than 85mg): Infuse intravenously over a period of at least one hour as directed

☐ MAINTENANCE: Inject 90mg SQ every 8 weeks after initial intravenous dose 60 Days Supply? ☐YES ☐NO Refills _____