Atopic Dermatitis
Patient Enrollment and Prescription Form

Gentry HEALTH SERVICES
Together Creating a Path to Better Care

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 _____ ICD-10 Code _____
Date of Diagnosis _____ Body Surface Affected: _____ %

☐ **Patient has moderate to severe atopic dermatitis (AD) that is inadequately controlled on prior or current topical therapy**

Drug Allergies _____ Latex Allergy? ☐YES ☐NO

Failed Prior therapies?

☐ Topical Corticosteroids:

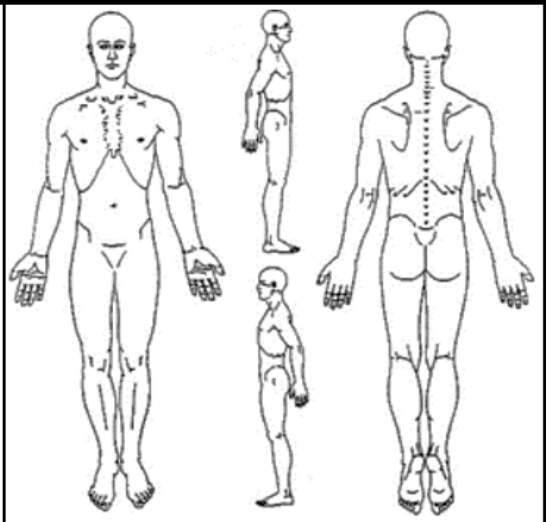
_____ _____ to _____
_____ _____ to _____

☐ Topical therapy not appropriate
Reason: _____

☐ Systemic Corticosteriods, Immunosupressants and/or Phototherapy:

_____ _____ to _____
_____ _____ to _____
_____ _____ to _____

☐ Systemic corticosteroids not appropriate
☐ Immunosuppressants not appropriate
☐ Phototherapy not appropriate
Reason: _____



Affected Areas: ☐Hands ☐Feet ☐Scalp ☐Groin ☐Nails ☐Face ☐Other: _____

Does the patient have history of conjunctivitis or keratitis? ☐YES ☐NO
Additional Comments _____

PRESCRIPTION INFORMATION

(please indicate days supply if different than suggested days supply)

☐Patient is 18 years of age or older
☐**Dupixent® (dupilumab)** ☐ 300 mg/2 mL Pre-filled Syringe with Needle Shield
☐ STARTER DOSE: 600MG SQ at week 0, 300MG SQ at weeks 2 & 4 Quantity: 4 Syringes Refills _____
☐ MAINTENANCE DOSE: 300MG SQ once every 2 weeks Quantity: 2 Syringes Refills _____

ADDITIONAL SUPPORTIVE MEDICATION

Medication Name and Dosage Form	Strength	Directions	Qty	Refills