Psoriasis and Psoriatic Arthritis Patient Enrollment and 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.

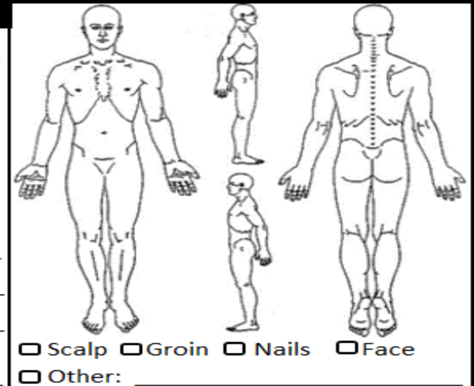
Prescriber Signature ____________________

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 ____________________ ICD-10 Code __________
Date of Diagnosis __________ Body Surface Affected: ________ %
TB positive? ☐ YES ☐ NO If yes, is the patient currently being treated? ☐YES ☐NO
HBV positive? ☐YES ☐NO If yes, is the patient currently being treated? ☐YES ☐NO
Drug Allergies ____________________ Latex Allergy? ☐YES ☐NO
Failed Prior therapies? ☐DMARDS: __________ Duration: __________
☐Topical: __________ Duration: __________
☐ Phototherapy: __________ Duration: __________
☐Specialty Meds: __________ Duration: __________
Does the patient have CHF? ☐YES ☐NO Does the patient have MS? ☐YES ☐NO
Additional Comments ____________________



☐ Scalp ☐Groin ☐ Nails ☐Face
☐ Other: __________

PRESCRIPTION INFORMATION

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

☐**Cimzia® (certolizumab)** ☐ 200mg/1ml Kit ☐200mg/1ml Prefilled Syringe
Directions: 400mg SQ Day 0, 14, and 28, then 200mg every other week Quantity ______ Refills ______

☐**Cosentyx® (secukinumab)** ☐ Prefilled Syringe ☐ Sensoready® Pen
☐ Plaque Psoriasis STARTER: 300MG SQ at weeks 0, 1, 2, 3, & 4 Quantity ______ Refills ______
☐ Psoriatic Arthritis STARTER: 150MG SQ at weeks 0, 1, 2, 3, & 4 Quantity ______ Refills ______
☐ MAINTENANCE Dose: Inject 300MG once every 4 weeks Quantity ______ Refills ______
☐ MAINTENANCE Dose: Inject 150MG once every 4 weeks Quantity ______ Refills ______

☐**Enbrel® (entanercept)** ☐ Vial ☐Prefilled Syringe ☐SureClick
☐ Directions: Inject 50mg SQ once weekly Quantity ______ Refills ______
☐ Directions: Inject 50mg SQ twice weekly Quantity ______ Refills ______
☐ Directions: Inject 25mg SQ twice weekly Quantity ______ Refills ______

☐**Humira® (adalimumab)** ☐Prefilled Syringe ☐Prefilled Pen
☐ Psoriasis Starter: 80mg SQ Day 1, 40mg Day 7, then 40mg every other week Quantity ______ Refills ______
☐ HS Starter: 160mg SQ Day 1, then 80mg on Day 15 Quantity ______ Refills ______
☐ MAINTENANCE: Inject 40mg SQ every other week Quantity ______ Refills ______
☐ MAINTENANCE: Inject 40mg SQ once weekly Quantity ______ Refills ______

☐**Otezla® (apremilast)**
☐ 28 Day Starter: Take as directed Quantity ______ Refills ______
☐ MAINTENANCE: Take one 30mg tablet twice daily Quantity ______ Refills ______

☐**Simponi® (golimumab)** ☐ 50mg/0.5ml Prefilled Syringe ☐50mg/0.5ml Smartject Autoinjector
Directions: Inject 50mg SQ once monthly Quantity ______ Refills ______

☐**Stelara® (ustekinumab)** ☐ Prefilled Syringe
☐ 45mg Starter: 45mg SQ on Day 0 and Day 28 Quantity ______ Refills ______
☐ MAINTENANCE: Inject 45mg SQ every 12 weeks Quantity ______ Refills ______
☐ 90mg Starter: 90mg SQ on Day 0 and Day 28 Quantity ______ Refills ______
☐ MAINTENANCE: Inject 90mg SQ every 12 weeks Quantity ______ Refills ______

☐**Tremfya™ (guselkumab)** ☐ 100mg/ml Single Dose Prefilled Syringe
Directions: Inject 100mg SQ at weeks 0, 4, and every 8 weeks thereafter Quantity ______ Refills ______

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.