Rheumatology 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	PRESCRIBER INFORMATION
Patient Name ______	Prescriber's Name ______
DOB ___/___/_____ SSN ______ Gender_____	Practice Name ______
Weight _____ Height _____ Phone ______	State License# ______ UPIN ______
Address ______	DEA ______ NPI ______
City, State, Zip ______	Address ______
Cell Phone ______ E-Mail ______ PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM	City, State, Zip ______
	Phone ______ Fax ______
Insurance Co. Name ______	Office Contact Person ______
Insurance Co. Phone ______ Group# ______	Prescription Date ______ Date Needed ______
Policy Holder Name ______	**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.**
Policy Holder Employer ______	
Relationship to Patient ______	**Prescriber Signature** ______
ID# ______ RxBIN ______ PCN______	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: ______

Has a TB test been performed? ❑ YES ❑ NO If yes, is the patient currently being treated? ❑ YES ❑ NO

Has patient been evaluated for HBV? ❑ YES ❑ NO If positive, is the patient currently being treated? ❑ YES ❑ NO

Does the patient have any other health conditions? ❑ YES ❑ NO If yes: ______

Drug Allergies ______ Latex Allergy? ❑ YES ❑ NO

Prior DMARD usage and for how long? ______

Lab Test Results (ESR, RF, Anti-CCP, ANA) ______

Lab Test Results: ANC ______ ALT ______ Platelet Count ______

PRESCRIPTION INFORMATION *(DAW requests must be handwritten)*

Medication	Dosing	Qty	Refills
❑ **Actemra® (tocilizumab)**	❑ Inject 162mg SQ every other week	Qty: 2	
❑ 162mg/0.9ml Prefilled Syringe	❑ Inject 162mg SQ every week	Qty: 4	
Other Dosing	❑ ______	Qty: ______	Refills ______
❑ **Cosentyx® (secukinumab)** ❑ Prefilled Syringe ❑ Sensoready® Pen	*****See Psoriatic Arthritis Form for PSA Prescribing***		
❑ **Ankylosing Spondylitis** STARTER Dose:	150MG SQ at weeks 0, 1, 2, 3, & 4	Qty: 10	Refills ______
❑ **Ankylosing Spondylitis** MAINTENANCE Dose:	Inject 150MG once every 4 weeks	Qty: 2	Refills ______
❑ **Cimzia® (certolizumab)** ***INITIAL DOSE***	❑ *Inject 400mg SQ at Days 1, 14, & 28*	Qty: 6	
❑ 200mg/1ml Powder Kit	❑ Inject 400mg SQ every 4 weeks	Qty: 2	
❑ 200mg/1ml Prefilled Syringe Kit	❑ Inject 200mg SQ every 2 weeks	Qty: 2	
Other Dosing	❑ ______	Qty: ______	Refills ______
❑ **Enbrel® (entanercept)**	❑ Inject 50mg SQ weekly	Qty: 4	
❑ Vial ❑ Prefilled Syringe	❑ Inject 50mg SQ twice weekly	Qty: 8	
❑ SureClick® Autoinjector	❑ Inject 25mg SQ twice weekly	Qty: 8	
Other Dosing	❑ ______	Qty: ______	Refills ______
❑ **Humira® (adalimumab)** ***INITIAL DOSE***	❑ *Inject 160mg SQ Day 1, 80mg Day 14*	Qty: 6	
❑ Prefilled Syringe ❑ Prefilled Pen	❑ Inject 40mg SQ weekly	Qty: 4	
❑ Crohn's Starter Kit	❑ Inject 40mg SQ every other week	Qty: 2	
Other Dosing	❑ ______	Qty: ______	Refills ______
❑ **Kevzara® (sarilumab) Prefilled Syringe**	❑ Inject 150mg SQ every other week	Qty: 2	
	❑ Inject 200mg SQ every other week	Qty: 2	Refills ______
❑ **Orencia® (abatacept)** ***INITIAL DOSE***	❑ *Infuse ______mg via IV, then Inject 125mg SQ within 24 hours*	*Qty:* ______	
❑ ClickJect Autoinjector	❑ Inject 125mg SQ weekly	Qty: 4	
❑ Prefilled Syringe Other Dosing	❑ ______	Qty: ______	Refills ______
❑ **Otezla® (apremilast)** ***TITRATION PACK***	❑ *Take 1 tablet as directed per titration schedule on packaging*	*Qty: 28 day*	
Maintenance Dose	❑ Take 1 tablet (30mg) twice daily as directed	Qty: ______	Refills ______
❑ **Remicade® (infliximab)** ***INITIAL DOSE***	❑ *Infuse ______mg over 2 hours at 0, 2 & 6 weeks*	*Qty:* ______	
❑ 100mg/20ml Vial	❑ Infuse ______mg over 2 hours every 8 weeks		
Other Dosing	❑ ______	Qty: ______	Refills ______
❑ **Simponi® (golimumab)**			
❑ Prefilled Syringe ❑ SmartJect®	❑ Inject 50mg SQ once a month		
Other Dosing	❑ ______	Qty: ______	Refills ______
❑ **Stelara® (ustekinumab)** ***INITIAL DOSE***	❑ *Inject 45mg SQ on Days 0 & 28*	*Qty: 2*	
❑ Vial ❑ Prefilled Syringe ***INITIAL DOSE***	❑ *Inject 90mg SQ on Days 0 & 28*	*Qty: 2*	
	❑ Inject 45mg SQ every 12 weeks	Qty: 1	
	❑ Inject 90mg SQ every 12 weeks	Qty: 1	
Other Dosing	❑ ______	Qty: ______	Refills ______
❑ **Xeljanz® (tofacitinib)** 5mg Tablet	❑ Take 1 tablet twice daily	Qty: 60	
11mg XR Tablet	❑ Take 1 tablet once daily	Qty: 30	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.