Gentry HEALTH SERVICES
Together Creating a Path to Better Care

Atopic Dermatitis
Patient Enrollment and Prescription Form

P: 1-844-443-6879 **F: 1-844-329-2447** ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, 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 ______________________
DEA ______________ NPI ______________
Address ______________________
City, State, Zip ______________________
Phone ______________ Fax ______________
Office Contact Person ______________________
Office Contact EMAIL ______________________
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

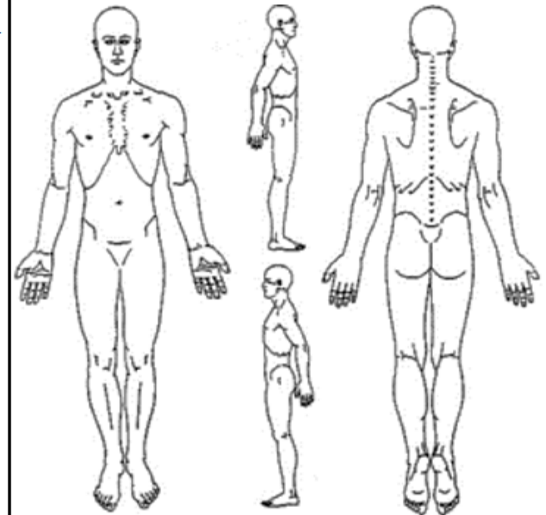
Reason: ______________________

☐ 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

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.