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 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.

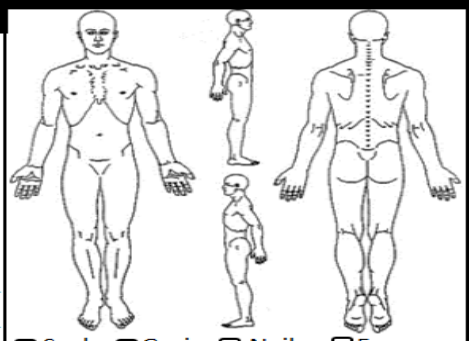
Prescriber Signature _____

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: _____ %
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

☐ **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)** ☐ 25mg Vial ☐ Prefilled Syringe ☐ 50mg SureClick ☐ 50mg Mini Prefilled Cartridge
☐ 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 _____

☐ **Taltz® (ixekizumab)** ☐ Prefilled Syringe ☐ Autoinjector
☐ Psoriatic Arthritis: 160mg week 0, then 80mg q4weeks Quantity _____ Refills _____
☐ Plaque Psoriasis: 160mg week 0, 80mg weeks 2, 4,6, 8, 10 & 12, then 80mg q4weeks 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 _____