



Rheumatology 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 **PRESCRIBER 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'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: _____ 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)

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

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