Asthma
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: __________ Years since diagnosed: __________

Number of severe exacerbations in the past 12 months: __________

☐ Patient has moderate-to-severe asthma that requires add-on maintenance treatment ☐ Atopic comorbidities

Eosinophil levels (if available)__________ cells/mcL Test date__________

IgE level (if available)________________ Test date__________

*****Please attach the patient's most recent CBC with differential**

Drug Allergies: ______________________________ Latex Allergy? ☐ YES ☐ NO

Other Disease States or Comorbidities ______________________________

Current Asthma Regimen

Therapy Type	Drug Name	Duration
☐ Bronchodilator Therapy		________ to ________
☐ Inhaled Corticosteroid		________ to ________
☐ Combination Therapy		________ to ________
☐ Oral Corticosteroid		________ to ________
☐ Other		________ to ________
☐ Other		________ to ________

PRESCRIPTION INFORMATION

☐ **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 ______

☐ **Dupixent® (dupilumab)** ☐ 200 mg/1.14 mL Pre-filled Syringe with Needle Shield

- ☐ STARTER DOSE: 400MG SQ at week 0, 200MG SQ at weeks 2 & 4 Quantity: 4 Syringes Refills ______
- ☐ MAINTENANCE DOSE: 200MG 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.