Tel: 844-443-6879 Fax: 844-329-2447

Crohn's Disease / Ulcerative Colitis
Patient Enrollment & Prescription Form

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 ______ Date of Diagnosis ______
ICD-10 Code: ______ New to therapy? ☐ YES ☐ NO
TB negative? ☐ YES ☐ NO Hepatitis B negative? ☐ YES ☐ NO
Drug Allergies ______ Latex Allergy? ☐ YES ☐ NO
Prior Therapy and for how long? ______
Reason for Discontinuation? ______
Any other relevant medical info? ______

PRESCRIPTION INFORMATION ***(DAW requests must be handwritten)***

☐ **Cimzia® (certolizumab)** ☐ 200mg/1ml Prefilled Syringe Starter Kit
Directions: Inject 400 mg SQ initially and at Weeks 2 and 4 Qty: 6 Refills 0
☐ 200mg/1ml Prefilled Syringe for Maintenance Dosing
Directions: ☐ Inject 400 mg SQ every 4 wks **OR** ☐ Inject 400 mg SQ every 2 wks Qty: QS 30 Days Refills ______

☐ **Humira® (adalimumab)** ☐ Crohn's 40mg Starter Package
Directions: Inject 160 mg SQ initially followed by 80mg two weeks later (Day 15) Qty: 1 KIT Refills 0
☐ 40mg Prefilled Pen Carton for Maintenance Dosing
Directions: Inject 40mg every other week Qty: QS 30 Days Refills ______

☐ **infliximab** ☐ 100mg/20ml Vial Qty: QS 30 Days Refills ______
Directions: ☐ Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks **OR** ☐ Infuse 10mg/kg at 0, 2 and 6 weeks, then every 8 weeks

☐ **Simponi® (golimumab)** TYPE: ☐ Smartject® Autoinjector ☐ Prefilled Syringe STRENGTH: ☐ 100mg
Directions: Inj 200 mg SQ initially at Week 0, followed by 100 mg at Week 2, then 100 mg every 4 weeks Qty: QS 30 Days Refills ______

☐ **Stelara® (ustekinumab)** ☐ 130mg Single Dose Vial ☐ 90mg single-dose prefilled syringe
☐ 260mg Starter (up to 55kg): Infuse intravenously over a period of at least one hour as directed
☐ 390mg Starter (greater than 55kg to 85kg): Infuse intravenously over a period of at least one hour as directed
☐ 520mg Starter (greater than 85mg): Infuse intravenously over a period of at least one hour as directed
☐ MAINTENANCE: Inject 90mg SQ every 8 weeks after initial intravenous dose 60 Days Supply? ☐ YES ☐ NO Refills ______

☐ **Xeljanz® (tofacitinib)**
☐ INDUCTION DOSE
☐ Take one 10mg tab twice daily for 8 weeks Qty: 120
☐ Take one 22mg XR tab once daily for 8 weeks Qty: 30
☐ MAINTENANCE DOSE
☐ Take one 5mg tablet twice daily Qty: 60 Refills ______
☐ Take one 10mg tablet twice daily Qty: 60 Refills ______
☐ Take one 11mg XR tablet once daily Qty: 30 Refills ______
☐ Take one 22mg XR 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.