

# 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** **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.

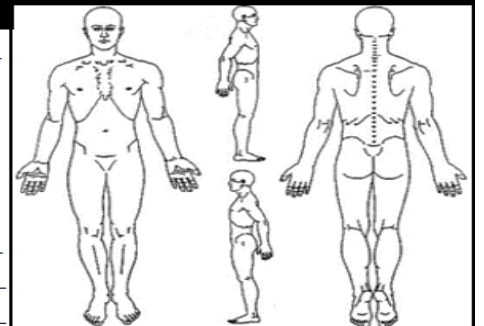
**Prescriber Signature** \_\_\_\_\_

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 \_\_\_\_\_ 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**

**Cimzia® (certolizumab)**  200mg/1ml Kit  200mg/1ml Prefilled Syringe  
 Plaque Psoriasis: 400mg SQ every other week Quantity \_\_\_\_\_ Refills \_\_\_\_\_  
 Psoriatic Arthritis: 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® (etanercept)**  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  Please check if Starter Dose is NOT needed  
 Psoriasis: 80mg SQ Day 1, 40mg SQ Day 8 and 22 then 40mg SQ every other week Quantity \_\_\_\_\_ Refills \_\_\_\_\_  
 HS 40mg Dose: 160mg SQ Day 1, then 80mg on Day 15 then 40mg SQ once weekly Quantity \_\_\_\_\_ Refills \_\_\_\_\_  
 HS 80mg Dose: 160mg SQ Day 1, 80mg Day 15 then 80mg SQ every other week Quantity \_\_\_\_\_ Refills \_\_\_\_\_

**Otezla® (apremilast) 30mg Tablet**  Please check if Starter Dose is NOT needed  
 Directions: Take starter dose as directed then take one tab twice daily Quantity \_\_\_\_\_ Refills \_\_\_\_\_

**Siliq™ (brodalumab)**  210mg Prefilled Syringe  Please check if Starter Dose is NOT needed  
 Directions: Inject 210mg SQ on week 0, 1 and 2 then every 2 weeks thereafter Quantity \_\_\_\_\_ Refills \_\_\_\_\_

**Simponi® (golimumab)**  50mg/0.5ml Prefilled Syringe  50mg/0.5ml Smartject Autoinjector  
 Directions: Inject 50mg SQ once monthly Quantity \_\_\_\_\_ Refills \_\_\_\_\_

**Skyrizi™ (risankizumab-rzaa)**  75 mg/0.83ml Prefilled Syringe  Please check if Starter Dose is NOT needed  
 Directions: Inject 150mg (2 syringes) SQ on Day 0 and Day 28 then every 12 weeks Quantity \_\_\_\_\_ Refills \_\_\_\_\_

**Stelara® (ustekinumab) Prefilled Syringe**  45mg  90mg  Please check if Starter Dose is NOT needed  
 Directions: Inject 1 syringe SQ on Day 0 and Day 28 then every 12 weeks Quantity \_\_\_\_\_ Refills \_\_\_\_\_

**Taltz® (ixekizumab)**  Prefilled Syringe  Autoinjector  Please check if Starter Dose is NOT needed  
 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 Syringe  100 mg One-Press  Please check if Starter Dose is NOT needed  
 Directions: Inject 100mg SQ at weeks 0, 4, and every 8 weeks thereafter Quantity \_\_\_\_\_ Refills \_\_\_\_\_